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Relationships Between Professional Development and Attitudes, Knowledge, and Skills in Play Therapy Among Counselors

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RELATIONSHIPS BETWEEN PROFESSIONAL DEVELOPMENT AND ATTITUDES, KNOWLEDGE, AND SKILLS IN PLAY THERAPY AMONG COUNSELORS

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Abstract

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Most counselors receive inadequate training in play therapy, through university counselor education programs, to counsel children using the method, which leaves novice counselors searching for workshops, institutes, conferences, or self-training to effectively meet the mental health needs of children with play therapy. In this first-of-its-kind study, the researcher investigated relationships between professional development and play therapy among working counselors and measured attitudes, knowledge and skills, and types of training in play therapy. A nonrandom sample of counselors were recruited from relevant online sources in this quantitative study. Attitudes, knowledge, and skills were measured by the self-reported Revised Play Therapy Attitude-Knowledge-Skills Survey (Kao, 2009).

The results of a MANOVA indicated a significant relationship between professional development and attitudes, knowledge, and skills in play therapy among counselors based on the various training types. The multiple regression analysis revealed that university training, institute/professional conference, and workshop training combined predicted higher attitudes; institute/conference training predicted higher skill level; and workshop training predicted higher knowledge. A simple linear regression revealed that knowledge predicts skills in play therapy.

APT membership demonstrated higher knowledge and skills mean scores when compared with non-APT members using a *t* test. Three hypotheses were confirmed at a statistically significant level: Counselors with university-level training had higher levels of attitudes, knowledge, and skills; knowledge in play therapy predicted high skill levels of the counselors; and APT membership related to higher levels of knowledge and skills.

Keywords: play therapy, professional development, professional counselors, elementary school counselors, training.

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Chapter 1

The Problem and Justification for the Study

Most counselors receive inadequate training in play therapy, through university counselor education programs, to counsel children using the method (Ebrahim et al., 2012; Shin & Gonzalez, 2018). This leaves novice counselors searching for workshops, institutes, conferences, or self-training to effectively meet the mental health needs of children with play therapy (Lambert et al., 2007; Ray et al., 2005; Van Horne et al., 2018). The significance of this problem is that children have developmental and emotional needs different from those of adults (Landreth, 2012; Ray et al., 2005). These needs are specifically addressed in play therapy, especially for children 3–12 years of age (Ray et al., 2005; Shin & Gonzalez, 2018). Knowing whether professional organization membership is influential and which types of training in play therapy are most effective in preparing counselors could result in better meeting the needs of children. This quantitative study focused on (a) which types of training relate to significantly increased attitudes, knowledge, and skills in play therapy among professional counselors and elementary school counselors who work with children 3–12 years of age in the United States and (b) the relative influence of membership in the Association for Play Therapy (APT) for these counselors.

The literature review revealed a paucity of research in this area, especially for practicing professional counselors (Carnes-Holt & Weatherford, 2013; Lambert et al., 2007; Ryan et al., 2002). So few studies exist on this group that conclusions were insubstantial. Carnes-Holt and Weatherford (2013) conducted a 2-day play therapy workshop training in a rural setting that resulted in five participants on Day 1 and three on Day 2. This was the only study found on professional counselors that looked at correlations between training/workshop evaluation and

attitudes, knowledge, and skills in play therapy. Further, Carnes-Holt and Weatherford reported no statistically significant findings. The authors instead proclaimed that the results revealed challenges rural counselors face along with the need for more counselors who provide play therapy in rural settings. Carnes-Holt and Weatherford's study was the only one found that examined attitudes, knowledge, and skills in play therapy among professional counselors. This lack of literature was concerning because, according to the experts, most professional counselors will work with children during their careers and thus will need competency in a method such as play therapy to be effective (Landreth, 2012; Lawrence & Kurpius, 2000; McNary et al., 2019).

The other two studies on professional counselors (Lambert et al., 2007; Ryan et al., 2002) found in the literature focused on counselors and professional organization membership in play therapy. The Lambert et al. (2007) research was sponsored by the National Play Therapy in Counseling Practices Project. The study compared counselors in the APT and the American Counseling Association regarding training hours, play modalities, theoretical orientation, and employment setting in play therapy (Lambert et al., 2007). The results indicated that APT membership made a statistically significant difference in the amount of continuing education received in play therapy. Ryan et al. (2002) surveyed members of the APT about continuing education, supervision, work setting, and distribution of play therapy in their workload. Their results showed correlations between number of workshop hours in play therapy and membership or number of years in the APT (Ryan et al., 2002). Neither of the studies explored the relationship between professional organization membership and attitudes, knowledge, and skills or types of training and attitudes, knowledge, and skills in play therapy among counselors.

Graduates from counselor education programs who serve children's mental health needs include not only professional counselors but also elementary school counselors (Bratton et al.,

2005; Ray et al., 2005; Shin & Gonzalez, 2018). Studies on this group were limited in scope regarding the stated problem (Pereira & Smith-Adcock, 2013; Ray et al., 2015; Shen, 2016). The school counselor studies primarily focused on evaluation of workshop training or the use of play therapy rather than overall professional development and training most beneficial to these counselors (Pereira & Smith-Adcock, 2013; Ray et al., 2015; Shen, 2016). A poignant finding in the literature was that school counselors are often the only providers of mental health services for children (Kagan & Landreth, 2009; Shin & Gonzalez, 2018; Van Horne et al., 2018).

As school counselors are the only mental health providers for many children (Kagan & Landreth, 2009; Shin & Gonzalez, 2018; Van Horne et al., 2018), professional development via continuing education is the primary means for counselors to obtain training in play therapy (Lambert et al., 2007; Ray et al., 2005; Van Horne et al., 2018). Play therapy is suited for meeting children's developmental needs (Ray et al., 2005; Shin & Gonzalez, 2018). Since most counselors likely will work with children during their career (Landreth, 2012; Lawrence & Kurpius, 2000; McNary et al., 2019), and yet so few studies have been conducted on the topic, an examination was needed of professional development in relation to attitudes, knowledge, and skills of counselors in play therapy. Professional development in this study was defined as the activity of engaging in various types of training and professional organization membership in play therapy (APT, 2020i; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016).

The term *counselor* in this study refers to elementary school counselors and professional counselors who at some point have counseled or will counsel children (Bratton et al., 2005; Ray et al., 2005). Counselors are prepared in university counselor education programs where they earn a master's degree in their specialty (CACREP, 2016). Counselors are also prepared to take

appropriate examinations for licensure or certification in their respective areas. The CACREP (2020) sets the standards for most university professional counseling programs that want accreditation in the United States.

The American Association of State Counseling Boards (AASCB, 2020) considers *professional counselors* to be those licensed to practice in the United States. The term *professional counselor* includes licensed clinical mental health counselors, licensed clinical professional counselors, licensed independent mental health practitioners, licensed mental health practitioners, licensed professional counselors, licensed professional counselors of mental health, licensed professional counselor-mental health services providers, or licensed professional clinical counselor, depending on the verbiage used by each licensing state or province. The majority of states, 64%, grant licenses to licensed professional counselors (AASCB, 2020). The remainder of the states, 36%, comprise the other professional counselor licensing. The AASCB is the national organization for counseling licensure regulatory matters for the United States (including the 50 states, the District of Columbia, Guam, and Puerto Rico). The CACREP (2020) provides counselor educators with the AASCB state counseling board information to help guide students in getting licensed after graduation.

In addition to a master's degree, elementary school counselors hold a certification in their state to provide academic, career, college, and social-emotional competencies to students in primary and intermediate schools (CACREP, 2016). The university school counseling program helps prepare school counseling students to work with children prekindergarten through Grade 12 (American School Counselor Association, 2019, 2020). Counselor education programs inform counseling students of the requirements of the state where they plan to work (CACREP, 2016). Elementary school counselors provide counseling to young children (American School

Counselor Association, 2019, 2020). They also help support families in obtaining outside service if students need long-term clinical counseling.

Because this research was focused on counselors who work with children, it was unique and needed. This was particularly true of practicing professional counselors, as very little has been published (Carnes-Holt & Weatherford, 2013). Surveying these counselors in the investigation provided new data for the field of counseling and an original contribution to the body of knowledge. The mental health of children is often overlooked, as people dismiss psychological disorders in children (Careers in Psychology, 2020). The literature revealed that even university counselor education programs focus primarily on adult counseling rather than children's mental health (Kagan & Landreth, 2009; Lambert et al., 2007; Ray et al., 2005; Van Horne et al., 2018). This project examined the professional development that child counselors receive in play therapy and whether or not they perceive having the attitudes, knowledge, and skills to provide this service.

The review of literature also demonstrated that most of the research about play therapy training consisted of program evaluations for graduate-level play therapy courses (Dillman Taylor et al., 2017; Kao & Landreth, 1997; Lindo, Chung, et al., 2012; Lindo, Meany-Walen, & Sullivan, 2012); as evaluations of continuing education units (Lambert et al., 2007; Ray et al., 2005); or as evaluations of short-term, self-produced workshops on play therapy (Carnes-Holt & Weatherford, 2013; Kagan & Landreth, 2009; Pereira & Smith-Adcock, 2013; Shin & Gonzalez, 2018). Therefore, assessment is needed of the variety of training sources and professional development for counselors in play therapy. A common assumption in the literature was that a great deal of training is required to provide play therapy and to ensure competent services

(Kottman, 2003; Landreth, 2012). Research on play therapy training practices among counselors in this study tested that assumption.

Recently, the APT has called for this type of research (Ray & McCullough, 2016). Play therapy has gained attention in recent years along with a need to understand how to best train counselors in this method (McNary et al., 2019; Thanasiu et al., 2018). Increased interest in play therapy, combined with growing evidence-based support, suggested the need for a better understanding of training for counselors in the field (Carnes-Holt & Weatherford, 2013; Flasch et al., 2017; McNary et al., 2019; Pereira & Smith-Adcock, 2013; Thanasiu et al., 2018). The data from this investigation give a better understanding of whether university training in play therapy results in improved attitudes, knowledge, and skills and whether types of training such as workshops and institutes offer similar results. The research also gives information about whether APT membership makes a difference in counselors' attitudes, knowledge, and skills in play therapy. The data offer insights into best practices in training and professional organization membership in play therapy. Professional organizational membership in play therapy was defined as professional membership in the APT or e-student membership in the APT (APT, 2020g).

Statement of the Problem

Most counselors receive inadequate training in play therapy at the university level to prepare them, which is a problem in meeting children's mental health needs (Lambert et al., 2007; Pereira & Smith-Adcock, 2013; Ray et al., 2005; Van Horne et al., 2018). The Centers for Disease Control and Prevention (CDC, 2020a) reported that approximately 20% of U.S. children experience mental disorders. The CDC also acknowledged the vacuity of effective mental health treatment for children. Many counselors are not prepared to counsel children (Kottman, 2003;

Landreth, 2012; Van Velsor, 2004). Therefore, counselors utilize professional development to receive the training needed to implement play therapy (Pereira & Smith-Adcock, 2013; Perryman et al., 2017; Van Horne et al., 2018).

Play therapy is a known therapeutic method addressing a wide range of presenting problems (Flasch et al., 2017; Pereira & Smith-Adcock, 2013). With a dynamic relationship between the child and counselor, play is utilized for exploration of feelings in an emotionally safe space (Ray et al., 2015). This versatile approach can be used across diverse populations in a variety of settings such as schools (Shin & Gonzalez, 2018) and clinical settings (Snow et al., 2009) to meet the developmental needs of children (Shen, 2016). Although play therapy has been practiced and researched for over 60 years (Lin & Bratton, 2015), limited training is available in university counselor education programs (Landreth, 2012; Shin & Gonzalez, 2018).

The background problem was that even though the number of university programs in play therapy has grown (Landreth, 2012), a gap remains between play therapy courses offered and the need in counselor education programs. According to the CACREP (2020), which accredits master's and doctoral degree programs in counseling and its specialties, 675 accredited programs are listed under master's level clinical mental health counseling, master's school counseling, and doctorate-level counselor education and supervision programs in the United States. According to the APT (2020j), only 152 U.S. universities offer play therapy courses. These numbers mean that approximately 22% or less of U.S. counseling education programs offer play therapy courses. The percentage is likely less, as some counseling programs are not CACREP affiliated.

Most counselors will work with children at some point during their career (Landreth, 2012; Lawrence & Kurpius, 2000; McNary et al., 2019). The university is where most beginning counselors get a view of what the counselor is supposed to do in sessions. The low percentage of

counselor education programs that offer play therapy courses is a problem. Amid the overwhelming need for mental health professionals specialized in working with children, the consensus is that the method of choice is play therapy (Homeyer & Morrison, 2008; McNary et al., 2019). Counselors who are trained in play therapy are a growing need. McNary et al. (2019) stated that a combination of foundational knowledge, advanced clinical skills, and supervision in play therapy is ideal for meeting this need.

What types of training are counselors actually receiving, however? Which type of play therapy training makes the biggest difference for counselors who serve children? Does professional organization membership in play therapy make a difference? The purpose of this study was to determine which types of training and whether professional organization membership in play therapy related to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors who work with children 3–12 years of age in the United States.

Research Questions

Three research questions guided this quantitative study:

1. What types of training in play therapy relate to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors?
2. Does the number of hours in play therapy training type have a relationship with the counselors' attitudes, knowledge, and skills in play therapy?
3. What is the relative influence of membership in the APT on attitudes, knowledge, and skills of play therapy between the two groups of counselors (those with and those without APT membership)?

Rationale for the Study

How would knowing about elementary school counselors' and professional counselors' attitudes, knowledge, and skills in play therapy based on their type of training or professional organization membership contribute original thought to the research literature? This study moved the focus away from program evaluation of play therapy training that primarily looked at graduate programs in counseling (Smith-Adcock et al., 2012). The focus was instead on a demographic who have been invisible in the publications: professional counselors working with children 3–12 years of age (Carnes-Holt & Weatherford, 2013). The study also included elementary school counselors who spend valuable time meeting children's emotional needs (Kagan & Landreth, 2009). By investigating the topic, a great deal was identified about training approaches that best prepare counselors in the method of play therapy based on counselors' perceptions. The study also looked at the differences in play therapy attitudes, knowledge, and skills between the APT membership group and the group without APT membership (see Heiman, 2014).

This study was relevant to the field of counselor education and supervision because it extended the understanding of play therapy methods utilized in counseling children; the training and preparation most effective for this method; professional organization membership influences; and an understanding of attitudes, knowledge, and skills in play therapy of counselors who counsel children (see Ray et al., 2005; Ray & McCullough, 2016; Schaefer, 2011). Such research and data are needed for credentialing bodies and universities to make decisions regarding counselor preparation (American Counseling Association, 2014; Carnes-Holt, 2014; Ray & McCullough, 2016). The results of this study, therefore, could be used to assist

professional counseling associations, credentialing boards, counselor preparatory universities, counselor educators, and counselors themselves (Shen, 2016).

The literature review included current research on preparation and training in counselor education and play therapy, the influences of professional organization membership in the APT, and the evaluation of the training counselors receive in play therapy (Carnes-Holt & Weatherford 2013; Flasch et al., 2017; Kagan & Landreth 2009; Pereira & Smith-Adcock 2013; Shin & Gonzalez, 2018). This information gave the reader a clear view of the preparation required of professional counselors and elementary school counselors (CACREP, 2016). The review also offered an awareness of the attitudes, knowledge, and skills essential for play therapy training (Muro et al., 2015). Evaluations conducted on play therapy training were analyzed as well (Carnes-Holt & Weatherford 2013; Pereira & Smith-Adcock 2013; Shin & Gonzalez, 2018). An overview of play therapy as a method was given, which included the definition, effectiveness, history, credentials available, professional associations, training required, and background information (APT, 2020a, 2020b, 2020c, 2020f, 2020h, 2020i; Jensen et al., 2017; Landreth, 2012; Lin & Bratton, 2015; Muro et al., 2015; Ray & McCullough, 2016). This review provided a depth and breadth of understanding for counselors interested in providing the play therapy approach.

Since scant literature has been published on counselors in regard to this study's interest, a pilot study was conducted in 2019 on elementary school counselors as part of this project to begin examining correlations (Anderson, 2019). The pilot study, *Attitudes, Knowledge, and Skills Among Elementary School Counselors*, was implemented to examine the correlation between school counselor attitudes, knowledge, and skills and various types of training in play therapy (Anderson, 2019). Training was viewed from a transformational learning theoretical lens

(Mezirow, 2004) in the quantitative research project. The sample size in the pilot study was 21 school counselors, of whom 95.2% held a school counselor certification, 85.7% held a master's degree, and 33.3% held a license in counseling. Based on the contact hours of training in play therapy, few of the school counselors had many hours of various types of training.

Frequencies run for each category showed that of the 21 respondents, 7 had university training, 6 had institute or conference training hours, 5 had workshop training, and 11 had no training at all in play therapy (Anderson, 2019). The results indicated that those with university coursework in play therapy had a positive relationship ($r = .547$) with the knowledge subset. Those who had taken university coursework showed increased knowledge compared with other forms of training. The study revealed a strong, positive, and statistically significant correlation between knowledge and skills in play therapy ($r = .923$, $p < .01$). The significance of that correlation suggested the need for a regression analysis to inquire as to whether knowledge does indeed predict skill level.

This pilot study endeavor was worthwhile for myriad reasons (Anderson, 2019). First, the study brought more awareness to attitudes of play therapy for counselors in this sample who work with the emotional needs of young children. Most of these counselors had a good attitude about children and play therapy but less knowledge and skills. The survey employed was the Play Therapy Attitudes, Knowledge and Skills Survey–Revised (PTAKSS-R). The PTAKSS-R is a 63-item tool with a Likert scale ranging from 1–5. The mean for the attitudes scale score was 4.39, the mean knowledge scale score was 2.93, and the mean skills scale score was 2.95.

The sample provided a glimpse into needed support for play therapy courses offered at the university level. A positive relationship ($r = .547$) was found between university coursework and knowledge and an even stronger positive relationship ($r = .923$) between knowledge and

skills in play therapy (Anderson, 2019). The results revealed the possibility of running a regression analysis to see if knowledge in play therapy predicts skill level (see Krathwohl, 2009). Further research could expand to a between-groups analysis (see Heiman, 2014). Since the literature reviewed indicated APT membership had an influence on various factors for counselors, a *t* test for independent samples could help in better understanding any statistical significance that needed to be recognized between counselors with and without membership for attitudes, knowledge, and skills in play therapy for this study (see Field et al., 2012).

Counselor educators should strive to contribute to the field through research and publication (American Counseling Association, 2014; CACREP, 2016). Publication through respected journals on the topic could allow associations to better collaborate with credentialing bodies regarding curriculum (Shen, 2008). This alliance could provide credentialing bodies with information needed to make decisions about counselor preparation for counseling children. The published research could give practicing counselors the evidence needed for them to express interest in play therapy to their counselor education institutions (Shen, 2008). Of course, collection of additional data is essential before researchers can draw inferences.

This study in play therapy could make a difference for the profession of counseling (see Creswell & Poth, 2018) in several ways. Findings could provide a map for those wishing to polish their play therapy methods skill set (Schaefer, 2011). The study was needed to support training that develops counselors in providing play therapy methods with better attitudes, knowledge, and skills (Muro et al., 2015). Findings could inform counselors without a background in play therapy regarding possibilities for counseling children more effectively (Ray et al., 2015). Additionally, the results could assist governing bodies in making decisions for counselor preparation (Shen, 2016).

Limitations of the Study

Limitations of a study can be described as difficulties obtaining accurate facts based on constraints in quantitative research (Krathwohl, 2009). These constraints included but were not limited to ethical standards, institutional constraints, and resource limits. Researcher bias was one limitation in this study, as I am a Registered Play Therapist, professional counselor, and certified school counselor. I believe in extensive education and training, particularly at the graduate level, in play therapy for counselors who work with children. The American Counseling Association (2014) emphasized that counselors minimize bias in designing and implementing research. To reduce bias, I conducted a quantitative project with an online anonymous survey (Creswell & Creswell, 2018). I was vigilant about separating out what was hypothesized and what could be informed during the analysis of findings (Heiman, 2014). Statistical procedures were utilized to further reduce bias and add credibility to the findings (Krathwohl, 2009).

Noteworthy is that although the CACREP (2016) has set minimal standards for counseling children under the school counseling specialty area, no standards have been written with respect to counseling children in the mental health clinical counseling specialty. This lack of standards was a limitation, as counselors do not have to be trained in play therapy to work with children and, therefore, may not be interested in the topic. Respondents included school counselors and professional counselors who served children yet had no training in play therapy (see Shin & Gonzalez, 2018). These respondents provided needed information on types of training hours in play therapy for counselors in the study. Overall, hours of training in play therapy and participation in the study were likely reduced secondary to lack of required standards, and this was noted in the results.

Though the intended population consisted of elementary school counselors and professional counselors within the United States, all elementary school counselors and professional counselors in the United States were not included, and therefore, the sample was not representative of the entire population (Krathwohl, 2009). External validity depended on the number of counselors who responded (Babbie, 2013). The sample was a large enough number to power the study and beyond, possibly enhancing external validity. The results might be able to generalize from this sample to all counselors in the United States if a simple random sample were obtained (Field et al., 2012). Without a random sample, external validity will be lacking, which could be a limitation of the study (Babbie, 2013). Internal validity could be a strong point in the study if the results supported the hypotheses, which were that counselors with more training will have higher reported attitudes, knowledge, and skills; counselors with higher levels of knowledge will have higher skills levels in play therapy; and that counselors with APT membership will have higher attitudes, knowledge, and skills than counselors without APT membership. If the study did not support those claims or hypotheses, then lack of internal validity would be a limitation (Heiman, 2014).

Another limitation was that the instrument used, the PTAKSS-R, was a self-report assessment (Kao, 2009). This survey relied on the honesty of participants along with a risk of social desirability influences. Social desirability might have influenced the answers of respondents in ways that could not be detected (DeVellis, 2017). Other extraneous factors, such as loss of interest or distraction, could have interfered with the results.

An unexpected limitation for this study was in context of the COVID-19 world pandemic (CDC, 2020b). These uncertain times may yield uncertain results. Participants might not have been in the frame of mind to respond. This specific context might reflect on the attitudes

subscale, for example. Effects of the threatening virus on counselors' frame of mind might have limited respondents. Counselors might have been less in touch with their play therapy skills as most were not meeting in person with children during the study period.

In summary, professional counselors and elementary school counselors should view the results of this study within the context of the limitations. Regardless of the limitations, however, the findings provide information about training approaches that best prepare counselors in the method of play therapy. The data contribute to scholarly literature and could influence university elective choices or professional development for professional counselors and elementary school counselors. Future research on this topic is needed to assist this group of counselors in becoming more aware of the benefits of play therapy, attaining more professional development in play therapy, and ultimately using play therapy as a method in the schools.

Definition of Significant Terms

Attitudes in Play Therapy. Attitudes in play therapy are measured by expressions of basic beliefs about children and a "way of being with children" (Kao & Landreth, 1997, p. 38).

Certified Elementary School Counselor. A school counselor holds a certification to provide academic, career, college, and social-emotional competencies to students in primary or secondary schools through a school counseling program (American School Counselor Association, 2019, 2020).

Intensive Institutes Training in Play Therapy. Concentrated training in the content area continues for several days with 6–8 hr per day. This intensive training includes summer institutes and professional conferences on the topic (Landreth, 2012).

Knowledge in Play Therapy. Knowledge in play therapy is measured by determining basic understanding of child-centered play therapy and children (Kao & Landreth, 1997).

Licensed Professional Counselor. A person holding a regular license as a professional counselor with authority to practice independently is a licensed professional counselor (Texas Administrative Code, 2019). The counselor provides a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (American Counseling Association, 2014).

Play Therapy. Play therapy is a systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic power of play to help clients prevent or resolve psychosocial difficulties, and achieve optimal growth and development (APT, 2020c). Play therapy is used by mental health professionals.

Professional Counselor. Counselors are licensed in the United States as regulated by their state boards in affiliation with the AASCB (2020). These include licensed clinical mental health counselors, licensed clinical professional counselors, licensed independent mental health practitioners, licensed mental health practitioners, licensed professional counselors, licensed professional counselors of mental health, licensed professional counselor-mental health services providers, and licensed professional clinical counselors, depending on the verbiage used by each licensing state or province.

Professional Development in Play Therapy. This term refers to the activity of engaging in various types of training and professional organization membership in play therapy (APT, 2020i; CACREP, 2016).

Professional Organization Membership in Play Therapy. Membership in APT includes professional membership and e-student membership (APT, 2020e, 2020g).

Registered Play Therapist. A person who has met stringent standards (APT, 2020b) to become a credentialed play therapist is known as a Registered Play Therapist, an APT-

trademarked term. Registered Play Therapists are licensed mental health professionals with extensive training, supervision, and education in play therapy. (Two additional trademarked credentials from the APT are Registered Play Therapist-Supervisor and School Based-Registered Play Therapist.)

Skills in Play Therapy. Skills in play therapy are measured by rating one's ability to transfer knowledge in play therapy into application of those skills with confidence (Kao & Landreth, 1996).

Types of Training in Play Therapy. Various types of training include workshops, intensive institutes, and university coursework (Carnes-Holt & Weatherford, 2013; Flasch et al., 2017; Pereira & Smith-Adcock, 2013). Play therapists can receive training in child-centered play therapy, Adlerian play therapy, expressive modalities, sand tray work, school-based play therapy, metaphor and theme work, tracking, filial play therapy, Theraplay, neurologically informed play therapy, group play therapy, and many other topics (APT, 2020c).

University Coursework in Play Therapy. This term refers to content-area-specific study in play therapy equivalent to 45 hr of instruction, per course, in clock hours rather than semester hours (Landreth, 2012).

Workshops in Play Therapy. Workshop training specific to the content area is concentrated in 1 or 2 days for 3–6 hr each day (Landreth, 2012).

Chapter 2

Review of Literature

To acquire a better understanding of the topic and to grasp key issues that need addressing, pertinent landmark studies were searched for in the existing body of knowledge (Hart, 2001). Consequently, considerable gaps were discovered in the literature where something new and original could be contributed. Currently, few, if any, studies have investigated types of training that are most beneficial to attitudes, knowledge, and skills in play therapy for elementary school counselors and professional counselors who work with children 3–12 years of age in the United States. The paucity of research in the literature is especially true in regard to practicing professional counselors (Carnes-Holt & Weatherford, 2013). Additionally, no studies were found examining the impact of APT membership on attitudes, knowledge, and skills of play therapy (Lambert et al., 2007).

The literature revealed that counselors do not receive adequate training in play therapy, particularly at the university level, to meet the mental health needs of children (Kagan & Landreth, 2009; Lambert et al., 2007; Ray et al., 2005; Van Horne et al., 2018). Many counselors are not prepared to counsel children (Kottman, 2003; Landreth, 2012). Therefore, they utilize other training sources to implement play therapy (Pereira & Smith-Adcock, 2013; Perryman et al., 2017; Shin & Gonzalez, 2018; Van Horne et al., 2018). The American Counseling Association's (2014) code of ethics stated that counselors should practice only within the boundaries of their competence based on their education and training. Lack of preparation in counseling children with methods such as play therapy then becomes an ethical issue (Shen, 2016). Research and data are needed to address these issues (American Counseling Association, 2014; Carnes-Holt, 2014; Ray et al., 2005).

Frequently, counselors face numerous challenges counseling children (Drewes & Schaefer, 2010). The CDC (2020a) reported that approximately 20% of U.S. children experience mental disorders. These disorders include attention-deficit/hyperactivity disorder (ADHD), behavior problems, anxiety, depression, autism, adjustment disorders, and more. The CDC also acknowledged the vacuity of effective mental health treatment for children. Therefore, counselors should focus on preparation and training for counseling children (Cochran et al., 2010). Numerous aspects are involved with training, preparation, and implementation of play therapy. This chapter focuses on play therapy as a method for counseling children and the related training needed for counselors.

In regard to professionalism, this literature study revealed that the major credentialing body for counselor education, the CACREP, has deficiencies in standards for counseling children (Shen, 2008). Minimal standards have been set under the school counseling specialty, and no standards have been established for counseling children in a clinical setting (CACREP, 2016). This was a grave concern considering that most counselors eventually will work with children (Landreth, 2012; Lawrence & Kurpius, 2000). The significance of this problem was that children have specific developmental and emotional needs that are different from adults, especially in counseling (Landreth, 2012).

According to the CACREP (2020), which accredits master's and doctoral degree programs in counseling and its specialties, 675 accredited U.S. programs are listed under master's level clinical mental health counseling, master's school counseling, and doctorate level counselor education and supervision programs. According to the APT (2020j), only 152 universities in the U.S. offer play therapy courses. This means that 22% or less of U.S.

counseling programs offer play therapy coursework. The low percentage of counselor education programs that offer play therapy courses is a problem.

Also, in regard to professionalism, no studies addressed the relative influence of APT membership on attitudes, knowledge, and skills of counselors in play therapy. Ryan et al. (2002) provided APT members with a survey instrument to better understand the demographics, characteristics, and attributes of the membership. The researchers looked at educational background, continuing education, supervision, work setting, and workload distribution of play therapy. They did not, however, explore attitudes, knowledge, and skills of play therapy as related to APT membership. Additionally, the continuing education subset in their study focused exclusively on members' workshop training and no other types of training (Ryan et al., 2002).

Lambert et al. (2007) conducted a study with results that indicated APT membership made a difference in the amount of continuing education or training received in play therapy. The researchers estimated that play therapists with membership in APT obtained between 88.29 and 118.64 more continuing education units in play therapy than play therapists who were only members of the American Counseling Association. Though they highlighted training and membership, the researchers did not measure the relationship of APT membership with attitudes, knowledge, and skills in play therapy. They did, however, measure university play therapy training. The overall number of play therapy courses taken in graduate school for the sample was 1.5 courses. The participants ($N = 891$) included in the Lambert et al. study were professional counselors (45% of the sample), school counselors (9.8%), and social workers (20.5%). The remainder were other mental health professionals (Lambert et al., 2007).

Of importance is that training in the method of play therapy is open to not only counselors, but also psychologists, social workers, marriage and family therapists, and other

related disciplines (APT, 2020a; Landreth, 2012; Ray & McCullough, 2016). The focus of this particular study is on professional counselors and elementary school counselors from counselor education programs. Reasoning for this sample is based on the adherence to counselor identity as taught in counselor education and supervision training (AASCB, 2020; American Counseling Association, 2014; CACREP, 2016).

The AASCB (2020) coordinates information on licensure for counselors, state by state. It is a national organization dedicated to representing counselors regarding licensure regulatory matters. The AASCB was created in 1986 by the American Association for Counseling and Development (now the American Counseling Association) to establish an organization that encourages communication between state licensing boards. An important source for counselor educators, the AASCB delineates the licensure requirements and titles of licenses regarding mental health counseling professionals.

Counselor Education Preparation and Training

CACREP-accredited program graduates are prepared for careers in a variety of settings (CACREP, 2016). Master's degree or entry-level graduates are prepared as counselor practitioners and are able to receive credentials (e.g., licensure, certification) in their specialty area. Doctoral-level graduates are prepared for counselor education, supervision, and practice. The counselor education program focuses primarily on training counselors for a set of professions. These professions include clinical mental health counseling (professional counselors); school counseling; rehabilitation counseling; addiction counseling; college counseling and student affairs; career counseling; and marriage, couples, and family counseling. Elective options complement these areas of study. Electives are selected under the guidance of

university advisors. Play therapy courses are elective options in some U.S. universities (APT, 2020j).

Investigating what university training is expected of counselors under the clinical mental health counseling specialty and the school counseling specialty revealed that the scope of content is structured by foundations, contextual dimensions, and practice with specific standards under each (CACREP, 2016). These standards must be documented within the curriculum by number and letter. Universities do have freedom within this framework to implement core coursework and electives with the stipulation that courses coordinate with CACREP (2016) basic standards. The core areas include professional counselor orientation and ethics, social and cultural diversity, human growth and development, career development, counseling and helping relationships, group counseling, assessment and testing, and research and program evaluation. Practicum experiences with supervision are also offered and required of students.

University Professional Counselor Training

Section 5: Entry-Level Specialty Area C, Clinical Mental Health Counseling, of the CACREP (2016) standards, states that students are prepared to address a wide variety of circumstances in mental health. Students must learn clinical mental health history, theories, biopsychosocial case conceptualization and treatment planning, etiology of disorders, psychological testing, and assessment. Students must understand the roles and settings of mental health counselors, modalities, the diagnostic process, crisis and trauma, psychopharmacology, legislation and government policies, cultural factors, ethical considerations, practice and management issues, and preparation standards for the profession. In practice, students must be able to conduct an intake mental health history, assess for caseload management, use techniques

and interventions, use strategies for interfacing with the legal system and other health care professionals, and use strategies to advocate for persons with mental health issues.

Practicum requirements include a minimum of 100 hr within a minimum of 10 weeks and then a 600-hr supervised counseling internship relevant to the student's specialty area (CACREP, 2016). Students meet with their supervisor weekly. Once all coursework, practicum, and internship are completed, the student graduates with a master's degree in clinical mental health counseling. Graduates are then able to sit for exams under their specialty for licensure or certification, such as the licensed professional counselor license or the national certified counselor credential.

Becoming a professional counselor who is licensed allows the counselor authority to practice independently (AASCB, 2020; Texas Administrative Code, 2019). Many licensed counselors work with children and families once employed or in private practice (Landreth, 2012; McNary et al., 2019). Aside from human growth and development across the lifespan, the counselor education curriculum does not focus on children or counseling for children (CACREP, 2016). Counselor education students with a specialty in clinical mental health counseling may be able to take play therapy courses or other courses focused on counseling children if offered as an elective (APT, 2020j; Landreth, 2012).

University School Counselor Training

In Section 5: Entry Level Specialty Area G, School Counseling (CACREP, 2016), the standard is that students are prepared to promote academic, career, and personal and social development of prekindergarten through Grade 12 students by using data-informed practices. They learn the history of school counseling; models of prekindergarten through Grade 12 education; counseling programs; and career development, consultation, and assessment. Students

must understand their role as a leader, advocate, and change agent and their responsibilities to parents, community, and school personnel. Students also must understand college and career readiness, emergency management, at-risk student characteristics, signs and symptoms of substance abuse in children and adolescents, common medications, professional organizations, legislation and government policies relevant to school counseling, and ethical considerations. In practice, graduates must be able to develop a school counseling program; provide guidance lessons; implement interventions for academic development; use techniques for personal and social counseling; examine connections between academics and social, familial, emotional, and behavior problems; examine ways to increase graduation rates; promote equity in student achievement and college access; foster collaboration and teamwork; implement peer intervention programs; and use data for decision making and advocacy.

Practicum requirements include a minimum of 100 hr within a minimum of 10 weeks and then a 600-hr supervised counseling internship relevant to the student's specialty area (CACREP, 2016). Students meet with their supervisor weekly. Once all coursework, practicum, and internship are completed, the student graduates with a master's degree in school counseling. Graduates are then able to sit for exams under their specialty for certification program (American School Counselor Association, 2020). Once the certificate is obtained, counselors are certified to work as an elementary or secondary school counselor.

Ray et al. (2005) espoused that elementary school counselors have a natural propensity toward embracing the concept of play as being children's language. This group of counselors sees the method as developmentally appropriate for the population they serve. Elementary school counselors tend to use play therapy in their work with students more readily than secondary

school counselors (Shen, 2008). Based on this evidence from the literature, including elementary school counselors' feedback was important in this play therapy study.

Essentials for Play Therapy Training

To sufficiently train a counselor in play therapy, a set of particular attitudes, knowledge, and skills is vital to the process (Jayne & Ray, 2015). The play therapist holds a set of specific beliefs about children and how to be with them in counseling (Landreth et al., 2009). Personal qualities help the counselor connect with children and form relationships (Jayne & Ray, 2015). Knowledge is needed of developmental levels, disorders and adaptive or maladaptive behaviors unique to children, the functions of play, and clinical skills. Additionally, the play therapist must be able to track, reflect, and facilitate spontaneity in a different way geared toward children's needs (Kottman, 2003; Van Velsor, 2004).

Landreth (as cited in Carnes-Holt, 2014) promulgated that counselors must learn exactly what they need to do during the session. This is especially true when working with children who have specific developmental needs (Shin & Gonzalez, 2018). In addition, the counselor must have patience and understanding (Van Velsor, 2004). Counselors must do the work needed to understand themselves fully (Landreth, 2012). Becoming comfortable with oneself as a counselor and developing a strong set of counselor and play therapist attitudes, knowledge, and skills are the foundation for this process (CACREP, 2016).

Attitudes of Play Therapists

The play therapist must believe in an acceptance of the child, that children have basic rights, and that children experience a depth of emotions (Jayne & Ray, 2015). The counselor possesses qualities such as empathy, warmth, genuineness, and unconditional acceptance (Rogers, 1980) to help facilitate the sessions. These qualities help children to feel free to express

themselves fully and thus ameliorate severity of symptoms and causes of distress (Yogman et al., 2018). With a healing attitude, the play therapist gives the child affirming messages such as, "I am here," "I care," "I hear you," and "I understand" (Landreth et al., 2009). The play therapist embraces the curious child within themselves.

The counselor must be able to "be with" the child (Landreth et al., 2009). Being fully present or "being with" provides heartfelt attention and interest needed to establish trust. This understanding and acceptance of the child's world offers an environment that unleashes the potential toward authentic functioning (Van Velsor, 2004). Within this environment is a high tolerance for ambiguity and uncertainty (Landreth, 2012). The child takes the lead, and the counselor believes that children can make their own decisions. Children are capable of self-direction if given the proper conditions and opportunities, in the session and in life. The counselor is not all knowing or authoritative but instead loving and open. Play therapists share the fundamental belief that play is good and necessary for physical and mental health (Kottman, 2003).

Play therapists have specific qualities revealed in their professional disposition (Jayne & Ray, 2015). In addition to being accepting, the counselor is nonjudgmental, kind, playful, joyous, and comfortable with children. Most importantly, the therapist has a sense of humor. The counselor must be self-aware (Landreth, 2012). Responses to children come from the counselor's humanness and self-acceptance. The counselor shows a willingness and love for working with children, reveling in the joy that children bring to the world. With patience and understanding, the play therapist is a one-of-a-kind adult in the children's lives (Jayne & Ray, 2015). This one-of-a-kind adult believes in focusing on the person rather than the problem, which means that the session remains in the present moment with tremendous respect.

Knowledge of Play Therapists

The qualified play therapist must understand development in children and the importance of play (Ray et al., 2005). The counselor education curriculum includes human growth and development across the lifespan, which provides the counselor with an understanding of child development (CACREP, 2016). Play is part of development that is essential to growth and well-being (Drewes & Schaefer, 2010). The counselor must have a clear understanding of the importance of play. Play is essential for children because it provides enhanced communication skills, self-esteem, decision-making skills, and problem solving (Davis et al., 2015). Considering this, integrating play into counseling sessions supports children's overall development (Drews & Schaefer, 2010).

Understanding of Play. Dr. Benjamin Spock, a well-known pediatrician and author, explained that play is serious business for children (Spock & Parker, 1998). Spock and Parker (1998) deemed play, particularly when noisy, disorderly, and unorganized, as vital for childhood development. Without exploratory play, children are at risk for physical illness, aggressiveness, and lack of mental acuity (Chudcoff, 2007). Another well-known physician, Dr. Bill Sears, a Harvard-trained pediatrician, is noted for an approach to family health making science simple and fun (Ask Dr. Sears, 2020). Dr. Sears encouraged imaginative play to develop confidence, language, social skills, movement, and cognitive abilities. He encouraged play in the play therapy room such as mirror play, dress up, sensory experiences, and the use of everyday items.

In a clinical report, Yogman et al. (2018) explained that children need a variety of skills, learned through play, to survive stressors today. These skills help to build executive functioning and a prosocial brain. Attunement, which can be achieved during play, is also key in developing strong, nurturing relationships. With the shifting culture, children are given fewer opportunities

to play. The American Association of Pediatrics actively promotes play, recess, and unstructured joyful discovery within the child's zone of proximal development (Vygotsky, 1978) to build 21st century skills through active engagement (Yogman et al., 2018). Play provides opportunities for adults to scaffold foundational skills for children in math, motor skills, social and emotional skills, and self-regulation. These foundational skills build the needed resilience that buffers against toxic stress. In their clinical report, Yogman et al. strongly encouraged pediatricians to write a prescription for play at each well-child visit.

Vygotsky (1978, 1966/2016) talked about the importance of play in children's intellectual development. He stated that children are always above their average age and behavior in play. Play actually accelerates mental development for very young children. Playfulness is associated with an increase in divergent thinking (Drewes & Schaefer, 2010). This thinking then assists children in developing coping skills for life. Being able to think up various ways to use a toy, for example, can open countless endings to stories, devise new scenarios, and increase divergent thinking (Drewes & Schaefer, 2010).

Even within the constraints and issues of our time, children continue to possess an innate desire to play, hang out, have fun, and relax (Weininger, 2001). Children are constantly negotiating freedom and risk (Chudacoff, 2007). Children hunger for freedom and independence while balancing dares and risks. Finding ways to use their imagination and play joyfully remains the building block for children's development. Play evokes joy, thought, language, social skills, learning, and a connection to others (Weininger, 2001). It is the link between the inner and outer world that weaves together intellectual, social, and emotional development. As Chudacoff (2007) put it, "Kids still find ways to be kids" (p. 213).

Children use play to explore their world, express feelings, experiment through role-play, stay physically healthy, and test their behaviors within real and imaginary relationships (Landreth, 2012). Play is unequivocally necessary for cognitive, emotional, and social development. Instinctively, from birth, children are motivated to meet their own needs. Children are therefore curious, motivated, and constantly learning about how to meet those needs. To better understand the stages of human development, theorists such as Piaget, Erikson, Kohlberg, and Gilligan created models to explain various periods or stages of human growth and development (Robb, 2006).

Developmental Models. Piaget (1929) noted that children are intrinsically motivated to construct a mental model of the world through interaction with the environment (McLeod, 2018b). The implications of Piaget's insights indicate that play as a means of discovery is ideal for learning about the world. Play is central to a child's schema, development, and adaptation. Erikson (1950) focused on psychosocial developmental stages in forming a sense of individual identity (Robb, 2006). For Erikson, the crux of development was about how individuals are unique. Kohlberg (1981) stated people arrive at moral maturity in a lived connection with others based on a set of principles. He determined that the process of moral development was concerned primarily with justice.

Gilligan (1982), conversely, studied girls' development from a care-based perspective, which considers mercy, connection, and relationships. She enlightened developmentalists and others with her book, *In a Different Voice*. She considered gender as directing development, which put a different lens on the topic. This view was different from Piaget, Erikson, and Kohlberg, who focused exclusively on male development (Robb, 2006). Gilligan argued that

boys and girls are socialized differently, which can be seen through their play. This difference is an important consideration for the counselor using play therapy methods (Landreth, 2012).

Gilligan (1982) explained that the experiences of girls had been invisible in developmental theory until she created a moral developmental theory that included girls. Gilligan discovered that females tended to score lower on moral development. This was because the scales were developed for males (McLeod, 2013). Gilligan asserted that girls are not inferior, just different in their moral development. Girls focus more on connections with people, a drive to care for others, and a quality of mercy in interactions. Gilligan's view is pivotal for counselors to consider while counseling both girls and boys (Landreth, 2012). Play therapy, at its core foundation, acknowledges all children based on individual needs and their unique voices.

Developmental Stages of Children. Developmental theories are formulated by theorists after considerable observation and research (McLeod, 2013, 2018a). Theorists outline stages that help to advise counseling theories. Counselors use these theories and developmental stages to help people strive toward what the set milestones identified by developmental theorists. Piaget established developmental stages for understanding children's development rather than the individual's needs over the lifespan (DeWolfe, 2018). Piaget (1929) offered an outline of development in children that continues to serve as a guide for teachers and counselors today (McLeod, 2018b). He focused on how children construct an understanding of their world based on schema or what they already know. The stages in Piaget's (1947) developmental theory are the following:

- sensorimotor, birth to 2 years
- preoperational, 2–7 years
- concrete operational, 7–11 years

- formal operational, 12 years and older

In the sensorimotor stage, children develop object permanence with the ability to form mental representations (Piaget, 1929). During the preoperational stage, children's thinking is egocentric. In concrete operational development, the child acquires the concept of conservation or concrete thinking but cannot reason abstractly. Finally, in the formal operational stage, children begin to reason abstractly. This abstract reasoning allows for engaging in conversations, beginning to critically evaluation situations, using symbols and metaphors, and functioning with greater spatial awareness (McLeod, 2018b).

Erikson's psychosocial developmental model considered psychological and social influences (Dunkel & Harbke, 2017). Erikson posited that relationships play a significant role in development. Erikson (1950) identified psychosocial stages expanded across the lifespan, from infancy through late life. Each stage was considered to be contingent on competency, which was the motivating factor. One stage must be mastered before moving on to the next. These stages are arranged as follows (Erikson, 1950):

- infant, trust versus mistrust
- toddler, autonomy versus shame and doubt
- preschool, initiative versus guilt
- school age, industry versus inferiority
- adolescence, identity versus role confusion
- young adult, intimacy versus isolation
- midlife, generativity versus stagnation
- late life, integrity versus despair

Erikson (1950) maintained personality development occurred in a series of stages. He was interested in how social interactions impacted development (Dunkel & Harbke, 2017). His work was unique in that he believed individuals could become stuck at various stages, unable to move on to the next until fulfilling the previous stage. Erikson's work was influenced by Sigmund Freud, who developed the psychosexual stages of development (McLeod, 2016). Freud's stages ranged from infancy to young adulthood and were focused on sexual development, according to McLeod (2016):

- infancy, oral
- toddler, anal
- phallic, phallic
- school age, latency
- adolescence, puberty
- young adult, genitality

Freud, according to McLeod (2016), primarily looked at childhood and adolescence when establishing stages. How parents dealt with the child's basic sexual and aggressive desires determined the child's personality. If the parents handled the stages well, the individual would grow to be well-adjusted. Freud described life as about a release of tension that resulted in pleasure. The six stages were ruled by what he called the id, which searches for pleasure. Once the individual moves into adulthood, the ego and superego develop to exercise greater control.

Kohlberg's (1981) stages of moral development borrowed from Piaget but leaned heavily toward moral reasoning (McLeod, 2013). Through a series of choices in interviews dealing with right or wrong, he devised a theory about how children's moral compass develops. Kohlberg maintained that people can only pass through these moral stages in order. He also stated that not

everyone achieves morality that is internalized. Kohlberg's stages of moral development are the following:

- birth to 9 years, preconventional
- 9–20 years, conventional
- after 20 years and maybe never, postconventional

In the preconventional stage, children avoid punishment and seek to gain rewards (Kohlberg, 1981). The conventional stage, for children and young adults, gaining approval toward duty that avoids guilt is the aim. Agreed-upon rights and personal moral standards are apparent in the postconventional stage. Since Kohlberg's sample consisted of only males, Gilligan (1982) began devising a developmental theory that included the female voice, which accounted for not only justice but also mercy (McLeod, 2013).

Gilligan (1982) focused on females in her expression of developmental stages (McLeod, 2013). Her stages allowed for sociopolitical and environmental issues. This model moved away from pathologizing individuals who do not fit the mode (Robb, 2006). Gilligan realized that developmental theories needed to be more inclusive to meet the needs of the broader population. Thus, Gilligan created a model that focused on girls' development in society. Her stages focused on stages of ethical care as follows:

- preconventional
- conventional
- postconventional

Notably, Gilligan did not attach ages to these stages. In the preconventional stage, the goal is individual survival (Gilligan, 1982). The child then transitions from selfishness to responsibility for others. The conventional stage is movement into self-sacrifice that is seen as

goodness. After this, the individual transitions from goodness to truth; this truth includes knowing that she is a good person, regardless. Finally, in the postconventional phase, the person adheres to the principle of nonviolence and the goal is not to hurt self or others. Gilligan (1982) included biological, systemic, and environmental factors in her work, which was considered revolutionary (McLeod, 2013; Robb, 2006).

Importantly, the CACREP (2016) standards include biological, neurological, and physiological factors that affect human development, functioning, and behavior. Also included in the standards are systemic and environmental factors that affect human development, functioning, and behavior in the curriculum for human growth and development in counseling. These factors must be considered when referring to a developmental and counseling theory (CACREP, 2016). Goals in counseling are to set in accordance with what is developmentally appropriate (Eells, 2015). Therefore, the counselor must have a good working knowledge of developmental stages in human growth and development (CACREP, 2016; Eells, 2015).

Knowledge of Play Therapy

A basic knowledge of clinical skills is first needed for counselors who provide play therapy (APT, 2020b). The counselor must be able to effectively assess the mental health needs of children (CACREP, 2016; Eells, 2015). The counselor must be able to provide a plan of treatment with goals and interventions (Eells, 2015). Consultation with parents as appropriate assists parents in better understanding their children (Schaefer, 2011). Referrals to community services, medical physicians and facilities, and resources may be necessary (American Counseling Association, 2014). In addition, the counselor understands themes, symbols, and succinct communication tailored for individual children in play therapy (Kottman, 2003).

The therapeutic power of play creates a therapeutic alliance between the counselor and a child who needs treatment (Schaefer, 2011). The child is able to communicate; self-regulate; achieve mastery; and work through abreaction, catharsis, and desensitization with the counselor. The counselor must have a firm understanding of these processes and stages (Van Velsor, 2004). Children rarely have the experience of control in their lives, but play offers that opportunity, which then can lead to mastery or control over their environment (Landreth, 2012). Abreaction is a reliving of a past experience in a safe space in an "as if" scenario (Schaefer, 2011). Children are able to pretend and project feelings onto objects in the playroom. Projection can help the child achieve catharsis or a discharge of strong emotions; this process leads to desensitization, which helps to neutralize fears and resolve psychological difficulties associated with trauma (Vicario et al., 2013). The key is to reestablish healthy connections with children throughout the process of therapy (Kottman, 2003; Miller, 1976).

In play therapy, the counselor must understand three important stages (Schaefer, 2011): rapport building, working through, and finally the termination stage. During the rapport-building stage, the counselor is gathering information, gaining trust, and getting to know the child. During this time, the counselor can let the child know that the playroom is a safe place for children to explore (Landreth, 2012). The counselor may say something like, "You are free to play with all of the toys in the playroom in any way that you would like, as long as you are safe." Much of the therapeutic change occurs during the lengthiest stage, working through (Schaefer, 2011). Play themes such as aggression, attachment, control, grief, gender, good versus evil, identity, limit testing, rescuing, safety, journeying, sexuality, and win/lose situations may become noticeable (Kottman, 2003). Counselors must allow time for the child to work through these themes toward

some resolution. The termination stage permits the family to take ownership, prepare for maintenance, and celebrate the progress (Schaefer, 2011).

The play therapist must have essential knowledge of the skills implemented in sessions (Landreth et al., 2009). Some of these include play themes, tracking, returning responsibility, therapeutic limit setting, choice giving, play materials needed, directive versus indirective approaches, theoretical focuses, and parent consultation (Landreth, 2012; Van Velsor, 2004). The primary step in actual practice is setting up the play space with necessary materials (Ray et al., 2015). This set up takes both knowledge and skills. Once the therapeutic milieu is set, the child is able to engage in ways that otherwise might remain hidden (APT, 2020c).

Skills of Play Therapists

The skill set of quality play therapists is essential to the process of play therapy (Landreth et al., 2009). A directive or nondirective approach can involve the use of both verbal and nonverbal skills. Nonverbal skills are critical, as in most clinical settings, for counselors who use microskills (Axline, 1947; Rogers, 1951; Van Velsor, 2004). These include showing interest, sitting facing the client, having an open posture, leaning in, making eye contact, exhibiting a relaxed demeanor, attending to the client, and matching affect (Eells, 2015). Verbal skills include tracking, reflecting content, reflecting feeling, returning responsibility, facilitating spontaneity, giving choices and encouragement, relationship building, and limit setting (Kottman, 2003).

Nondirective play therapy is a self-led play experience in the presence of a counselor who communicates child-centered responses (Schaefer, 2011). During this process of continual discovery, the play therapist provides understanding and acceptance (Jayne & Ray, 2015). The child feels free to explore and express dimensions of themselves without fear of judgment. A nondirective approach allows for spontaneous play (Axline, 1947). This approach works well for

children who are able to understand symbolic concepts, emotionally self-regulate, and negotiate with others (Stagnitti & Pfeifer, 2017).

In directive play therapy, the counselor structures the play activities, wherein cofacilitation is a defining feature (Stagnitti & Pfeifer, 2017). Directive play therapy shares some characteristics of nondirective play therapy in regard to unconditional positive responses and allowing the child to lead. The counselor makes the decision for directive play therapy after an assessment of the child's play ability, thereby assuming responsibility for guidance and interpretation. Some theories, such as Adlerian, Jungian, and Gestalt, encourage a more active stance on the part of the counselor, and therefore align with a more directive approach (Green et al., 2013; Kottman, 2003; Oaklander, 2001).

By providing reflective affirming messages, tracking, and being with, the play therapist seeks to understand the whole child from the child's worldview (Ray et al., 2015). The counselor reflects upon activity and feelings during the session (Van Velsor, 2004). This reflective activity helps to build rapport with statements such as, "You know just where that goes" or "You are very proud of yourself." Tracking is another technique that affirms what the child is choosing in play (Kottman, 2003) and includes two methods: direct and indirect. In direct tracking, the counselor tracks what the child is doing (Van Velsor, 2004). In indirect tracking, the counselor tracks what the objects are doing (Landreth, 2012). Responses from the counselor may include, "I see that you are playing with the sand," "Now the daddy doll is leaving the dollhouse," or "Hmmm, you are trying to decide what you want to play."

Reflecting or restating content is a matter of paraphrasing what the child understands or expresses in the playroom while engaged in play (Kottman, 2003). An example is, "You know a lot about cars and trucks." Reflecting feeling is focused on expressed feelings or actions in the

playroom (Ray et al., 2015). An example might be, “You are getting really frustrated with that toy,” or “It makes you angry that you cannot open that.” The counselor must be in tune with the child’s play and affect to reflect messages properly (Jayne & Ray, 2015). To encourage spontaneity in play, the therapist might say, “You can paint that in any way you like” or “You can use whatever colors you want.” The counselor must be sensitive to using age-appropriate vocabulary with proper intonation and not come across as parroting the child. Kottman (2003) recommended that the counselor get down on the child’s level to convey respect and genuineness.

Before any of this can be established in sessions, a relationship of trust is imperative (Schaefer, 2011). Just as in all counseling sessions, the play therapist works initially to establish rapport. By providing empathy, acceptance, and understanding, the therapist encourages the child to feel free to honestly self-express (Jayne & Ray, 2015). The counselor may make statements such as, “That’s okay, accidents happen,” “That happens to me too sometimes,” “You are upset with me,” or “You are wondering how I feel about that.” The foundation for change within this method is based on a good therapeutic relationship (Landreth et al., 2009). Words of encouragement are self-esteem builders that focus on ways that the child is capable of figuring things out, overcoming obstacles, and solving problems. The counselor can express this by stating, “You’ve got this,” “You have so many ideas,” or “You did it!” Kottman (2003) stated that in sessions the counselor encourages the effort but does not praise results.

Limit setting is used in both nondirective and directive styles as a necessary part of play therapy for therapeutic and practical purposes (Landreth & Bratton, 1999). Boundaries help to provide safety, predictability, and security. Play therapy is not completely permissive, although limits may appear to be minimal. Limits in the session are not set until they are needed in the

moment (Landreth, 2012). Examples are, “I know that it may seem fun to hit me, but I am not for hitting,” and “The bobo doll is made for hitting in here.” By providing acceptable alternatives, the child learns to self-correct (Schaefer, 2011).

Determining progress in play therapy can be challenging, as children rarely make dramatic breakthroughs (Landreth, 2012). Change is usually gradual and slow but is occurring in small increments. The counselor looks for firsts in the session such as the first time not having to set a limit. The counselor observes themes and changes in themes such as now the child is the hero instead of the parent (Kottman, 2003). The counselor looks for signs of independence, confidence, expression of feelings, acceptance of responsibility, flexibility, meaningful play, self-correction, recovery from disappointment, reduction in symptoms, self-directed sustained play, and imaginative play (Ray et al., 2015).

All of the skills described in this section are essential for the counselor who implements play therapy in sessions (Schaefer, 2011). To learn and incorporate play therapy skills into counseling sessions, various types of training options are available (APT, 2020b, 2020i). The APT provides conferences at the national and state levels, webinars, self-study through books, materials, and DVDs. Registered Play Therapists and other qualified professionals offer workshops. Universities such as the University of North Texas offer summer institutes and intense supervision training in play therapy (Center for Play Therapy, 2020). Some university counselor education programs offer play therapy coursework as electives or incorporate play therapy into course classes as appropriate (APT, 2020j; Landreth, 2012).

Only 22% or less of CACREP-accredited universities offer play therapy in their counseling program (APT, 2020j), which is a concern. Therefore, it was interesting to survey counselors on their types of training as it correlates to attitudes, knowledge, and skills. This study

also was designed to see if the counselors surveyed had any play therapy training, at all. Though not included in the study, the literature review covered other possible methods for counseling children. If counselors do not employ play therapy, what other methods are they using? How effective are these methods with children 3–12 years of age?

Approaches to Counseling Children

In addition to play therapy, counselors can use other approaches or methods while counseling children (Bratton et al., 2005; Lin & Bratton, 2015). Benefits, limitations, and criticisms of each approach are discussed to provide a clearer understanding. These methods include cognitive behavioral therapy (CBT; Halder & Mahato, 2019; Ridings et al., 2019), mindfulness-based interventions (Guest & Carlson, 2019; Lemberger-Truelove et al., 2018), and solution-focused therapy (Bond et al., 2013; Carlson, 2017). These three were the perspectives most represented in the current literature.

CBT is one of the most evidence-based approaches used with children today (Halder & Mahato, 2019; Ridings et al., 2019). One of the key features of CBT for children is the neutralizing of behavior problems. To be effective, the parents or guardians must be actively involved in the process (Ridings et al., 2019). The first few sessions are devoted to assessment and treatment planning, which then guide the sessions (Halder & Mahato, 2019). Counselors teach the child to recognize automatic thoughts and link emotional states to those thoughts. Since this approach is geared toward use of language and communication, those in middle childhood to older children are more suited for CBT. Halder and Mahato (2019) suggested that younger children may benefit more from a behavioral approach using reinforcement techniques. Lin and Bratton (2015) also reported that behavioral techniques historically have been favored for young children.

Despite the evidence base of CBT, the practice for children is not without issues (Halder & Mahato, 2019). One of the limitations includes parents wanting to use counseling solely for behavior management. Those who are drawn to CBT also tend to prefer psycho-pharmaceutical interventions, which may raise concerns (Halder & Mahato, 2019). Some parents may resist being so actively involved in the therapy. Further, children often are not explicit in their communications with adults. This communication gap can create frustration in attempting to fully understand the psyche of children. Other children experience difficulty sitting and focusing for long periods of time. Halder and Mahato (2019) expressed that CBT is a better mental health treatment for children 13 years or older.

Mindfulness training in combination with social and emotional learning can be effective in self-regulatory growth of children (Lemberger-Truelove et al., 2017). Siegel (2007) purported that mindfulness approaches promote emotional regulation in the brain. This regulation improves attuned communication, emotional stability, empathy, and fear reduction. Children can learn to adopt a language of kindness that becomes internalized over time (Lemberger-Truelove et al., 2017). Lemberger-Truelove et al. (2018) conducted a mixed method study to examine social-emotional learning and mindfulness-based interventions. Results from the quantitative portion did not reveal statistically significant findings for peer interactions or self-regulation for 3- to 4-year-olds, but the qualitative observation part of the study revealed changes. Students in the treatment group compared to the control group demonstrated improved task orientation and orientation to experiences (Lemberger-Truelove et al., 2018).

A concern for the mindfulness-based approach in counseling children is potential inequities in support beyond the skill training (Lemberger-Truelove et al., 2018). Mindfulness-based interventions could be interpreted as assuaging children or having some judgmental

effects. Some children may resist this method in counseling as it differs culturally or spiritually from home experiences. In the current mindfulness zeitgeist, counselors need to be aware of providing fidelity in treatment so that attentiveness to the experience has healing rather than deleterious effects. Regardless of the cautions presented, counselors can foster growth and kindness to help children improve with mindfulness-based methods. The journal articles have not, however, addressed whether the method is developmentally appropriate for children 3–12 years of age.

Solution-focused therapy is a strengths-based approach that can be referred to as a positive change method (Bond et al., 2013). Brief and short term, solution-focused therapy is thus appealing to staff in institutions such as hospitals and schools (Pereira & Smith-Adcock, 2013). The counselor and student work collaboratively to create goals based on strengths, past successes, and future plans in a sharply focused manner. The scaling question, which states "on a scale of 1–10," is used by the counselor to track progress. Growing evidence suggests that solution-focused therapy is effective for working with children, particularly those with moderate behavior difficulties (Bond et al., 2013).

Bond et al. (2013) presented a systematic literature review that was generally supportive of solution-focused therapy. Two of the studies indicated that this method worked well with children who have learning disabilities. Improving self-concept was noted as an area beneficial for these children. Solution-focused therapy is often used in combination with other methods for best results. A weakness of solution-focused therapy noted in the review was a focus on the process more than outcomes (Bond et al., 2013). The method was more effective with children who had moderate rather than severe behavior difficulties.

Similar to findings in adult studies, no one method is superior to the others (Bratton et al., 2005). Each has distinct advantages and disadvantages regarding use with children. Selecting methods can vary based on the counselor's level of training, competencies, the child's age, and individual needs. CBT, mindfulness training, and solution-focused methods depend on talk therapy, which is developmentally inappropriate for most children. Rarely do young children want to sit and talk about their feelings (Landreth, 2012). These methods have prerequisites such as verbal expression, understanding of complex issues, and insights (Bratton et al., 2005).

Play therapy is unique, however, in that it meets the developmental needs of the child (Kottman, 2003), particularly among children 7 years and younger (Lin & Bratton, 2015). The majority of children, even below the age of 11, lack the capacity for abstract thought. Therefore, counselors must be keenly cognizant of developmental level when counseling children. Play therapy is distinctly ideal for meeting the needs of children 3–12 years of age (Bratton et al., 2005; Lin & Bratton, 2015; Shin & Gonzalez, 2018).

Play therapy has some disadvantages, nonetheless, as it is largely dependent upon the skills of the counselor (Karjala, 2017; Myrick & Green, 2012; Ray et al., 2005). A counselor who invests in knowing the child's personality and truly understands the joyful wonder of play will find the most productive theory within play therapy for approaching sessions. Some have described play therapy as a simple solution to complex problems; contrary to this criticism, it is a complex method that requires specialized training (Flasch et al., 2017). This expressed disadvantage reinforces the claim that as play therapy is an approach to counseling that requires special skills, a great deal of training is required (Flasch et al., 2017; Kottman, 2003; Landreth, 2012). The APT noted in their evidence-based practice statement (Ray & McCullough, 2016)

that of utmost importance in research findings was that the counselor be well trained and knowledgeable in play therapy for the method to be most effective.

Effectiveness of Play Therapy

Play therapy is used effectively in the treatment of externalizing behaviors, ADHD, encopresis, trauma, obsessive compulsive disorder, anxiety, autism, and other emotional/behavioral issues (Bratton et al., 2005; Daniel, 2019; Green et al., 2013; Meany-Walen et al., 2015; Myrick & Green, 2012; Vicario et al., 2013). These topics are well represented in the scholarship and publications related to play therapy. Mental health facilities, schools, hospitals, and private practitioners utilize play therapy as an intervention regarding various diagnoses (Carlson, 2017; Homeyer & Morrison, 2008). Play therapy also has been found effective in academic and social development (Ray et al., 2015; Shin & Gonzalez, 2018).

Three meta-analytic reviews were examined to delve more deeply into treatment outcomes of play therapy (Bratton et al., 2005; Jensen et al., 2017; Lin & Bratton, 2015). Jensen et al. (2017) reviewed 100 studies comparing outcomes for children and adolescents. The results indicated small to moderate benefits (d = .44) for play therapy across all outcomes. After four studies with an extremely large effect size were removed, the effect size was d = .36. The benefits of play therapy were about half of those for behavioral approaches (Jensen et al., 2017). Bratton et al. (2005) also found that the evidence tended to favor behavioral techniques. They reviewed 93 controlled outcomes studies, published 1953–2000, to assess the efficacy of play therapy along with factors that impact effectiveness. Lin and Bratton (2015) analyzed effectiveness of various approaches in child counseling. Behavioral therapy, CBT, and play therapy methods were the three treatment models found to be most prevalent in the literature.

Behavioral approaches, again, had the highest average effect size. Child-centered play therapy was found to be most effective with children 7 years or younger.

Bratton et al. (2005) discovered more positive effects for humanistic than nonhumanistic treatment. Their comprehensive review resulted in support for play therapy, particularly in regard to its efficacy with children suffering from emotional and behavioral difficulties. The overall treatment effect for play therapy interventions was .80 standard deviations. Engaging parents in play therapy produced the largest effects, particularly with children 11 years or younger. Lin and Bratton (2015) also found that involving parents in play therapy resulted in better outcomes. Children 8 years or younger responded best in this category. They reviewed 52 controlled outcome studies 1995–2010, and the results showed moderate treatment effect size (d = .47) for child-centered play therapy (Lin & Bratton, 2015). Overall, the findings supported play therapy as a beneficial treatment for child counseling. Child-centered play therapy was considered developmentally appropriate and culturally responsive to the needs of children (Lin & Bratton, 2015).

All of the authors of the meta-analyses reported that small sample size limited statistical power of the results but that the meta-analysis gave more power by combining findings and computing overall treatment effect (Bratton et al., 2005; Jensen et al., 2017; Lin & Bratton, 2015). This methodology, meta-analysis, then made the results more generalizable. Play therapy is generally used to treat problems without a specific diagnosis, and thus assessing it as an empirically supported treatment was difficult. If more diagnostic criteria were included, then play therapy could be compared broadly with other methods of treatment of specific disorders (Jensen et al., 2017). Additionally, no studies were available with randomized control trials.

After reviewing individual studies, the two most prolific areas in the literature regarding effective treatment of play therapy were for ADHD and highly disruptive externalizing behavior problems (Green et al., 2013; Ritzi et al., 2017; Van Horne et al., 2018). Cochran et al. (2010) stated that aggressive, disruptive, and maladaptive behavior of children is one of the most common reasons for counselor referrals. Children with ADHD often struggle with behavior issues, off-task behavior, and a pattern of inattentiveness or impulsivity, which interfere with daily functioning (American Psychiatric Association, 2013). This diagnosis, coupled with adverse childhood experiences such as violence, crime, abuse, trauma, and poverty, results in children with decreased regulation of emotions (Patterson et al., 2018; Post et al., 2019; Vicario et al., 2013).

Patterson et al. (2018) conducted a quantitative study of 12 African American youth 5–9 years of age, who lived in adverse conditions. The researchers provided child-centered play therapy for 6 weeks to these children, who were teacher nominated individually. Patterson et al. noted that group play therapy reinforced more expression in play. The Impaired Rating Scale and the Spence Anxiety Scale were each applied three times during the study. Results indicated an overall decrease in overall behavior difficulties. The study measured not only behavior difficulties, but also anxiety and worry. Students showed a more significant decrease in anxiety and internalizing behaviors than in externalizing behaviors. Additionally, the researchers found that protective factors are helpful in reducing mental health issues for those with adverse childhood experiences. Those factors included positive family, peer, school, and neighborhood influences (Patterson et al., 2018). Resiliency is strengthened as a result of protective factors in a child's life.

Ritzi et al. (2017) performed a similar study in Australia. They found that play therapy reduced externalizing behavior problems in children at a statistically significant level. The participants were English-speaking children between the ages of 6 and 9 years who demonstrated high levels of problematic behavior based on the Child Behavior Checklist parent report or teacher report assessment. These instruments, created by Achenbach and Rescorla (2001), proved to be sound based on the reliability and validity results. Twenty-four participants qualified and completed the study. The parents or guardians agreed to complete pre-, post-, and follow-up assessments. The qualifying participants were randomly assigned to a treatment group or to a wait-list control group. Play therapy was conducted twice daily for 10 days by qualified play therapists at four different locations to accommodate the treatment group. The wait-list control group received no intervention. Posttesting showed that those who received the intervention improved externalizing behaviors at a statistically significant level.

Green et al. (2013) conducted a case study of a 13-year-old boy diagnosed with ADHD who was on medication to treat his hyperactivity and impulse control. Even with medication, the adolescent displayed severe externalizing behavior problems. Jungian play therapy was used as an intervention, with a focus on mandalas for self-healing. The sessions were conducted twice a week for 3 months. The intervention began with predrawn mandalas and graduated to self-drawn mandalas including two or three symbols. The role of the counselor, who was highly trained in Jungian play therapy, was to provide the activities, believe in the process, and allude to the psychological issues that needed to be integrated.

The results from clinical vignettes indicated that the 13-year-old studied was able to relax and gain access to his interpersonal strengths (Green et al., 2013). He reported feeling less stressed when reaching out to others in social contexts. Peer interactions improved as he became

more emotionally available to others. Fewer incidents of bullying occurred as he was able to self-advocate by reaching out to school leaders (Green et al., 2013). By integrating symbolic and real life, the therapy paved the way for intrapsychic self-healing that allowed the unconscious to come to the level of consciousness.

Hashemi et al. (2018) conducted a quantitative study examining the efficacy of short-term play therapy for children in reducing symptoms of ADHD. Six children 7–10 years old with ADHD were selected through purposeful sampling from Iranian private and public schools. The participants received 10 sessions of play therapy and a follow-up after 3 months. The instruments, Conner's Parent Questionnaire and the Child Behavior Checklist, were administered weekly. The results indicated that play therapy was effective in reducing symptoms of ADHD by 45%. Further, parental involvement supported growth, which then bolstered the parents' mental health. Therapists trained parents on methods of play therapy 15 minutes each week. This training proved to decrease parental stress toward positive outcomes for their children with ADHD.

Two individual studies resulted in children needing a more integrated approach (Glazer, 1998; Glazer & Clark, 1999). Glazer (1998) found that play therapy alone was not enough for grieving children. Filial play therapy, as part of intervention, provided evidence in helping parents cope with more empowerment, which then helped the children (Glazer & Clark, 1999). Filial play therapy is an approach that teaches parents how to employ play therapy with their children in sessions (Schaefer, 2011). Chen and Panebianco (2018) discovered that while using play-based methods, parental involvement was the key ingredient for success. No direct evidence was reported regarding children's change in functioning as a result of play therapy alone (Chen & Panebianco, 2018; Glazer, 1998; Glazer & Clark, 1999).

Most studies supported the overall effectiveness of play therapy (Green et al., 2013; Hashemi et al., 2018; Patterson et al., 2018; Ritzi et al., 2017). Child-centered play therapy was found to be the most effective method for meeting children's developmental needs (Lin & Bratton, 2015; Patterson et al. 2018; Ritzi et al., 2017). In the meta-analyses, play therapy was most effective with younger children and when parents are involved in treatment. Play therapy was effective in reducing symptoms of ADHD, while also lessening disruptive, maladaptive, and externalizing behaviors. Though play therapy was effective, behavioral interventions were most effective based on treatment outcomes. The studies unveiled the importance of a positive support network for children. One of the advantages of play therapy is that the counselor works not only with the child, but also with the parent, guardian, school, or whole family. When a child's support system is available to strengthen treatment goals, results can increase exponentially. Chen and Panebianco (2018) found parental involvement to be the most significant factor in child therapy. In two studies (Glazer, 1998; Glazer & Clark, 1999), an integrated approach to counseling was discovered to be more influential than play therapy alone.

To reinforce the effectiveness of play therapy, the APT provided an evidence-based practice statement (Ray & McCullough, 2016) with a plethora of supporting data. This evidence-based practice statement is based on research in the literature from 2000–2006 that involved direct application of play therapy for children (Ray & McCullough, 2016). The findings from four meta-analyses, one randomized control trial with a sample size of 25, four quasi-experimental studies, nine single-case experimental designs, 11 repeated-measures single-group studies, and 20 qualitative and case studies supported the use of play therapy as a primary communication tool for children to reduce life difficulties. Of utmost importance in the findings was the requirement of a well-trained and knowledgeable counselor in play therapy methods who

has been supervised in practice. Play therapy is, therefore, more than watching children play with toys (Kottman, 2003). When providing services, counselors use techniques, procedures, and modalities that are grounded in theory with a scientific foundation (American Counseling Association, 2014).

What Is Play Therapy?

The APT (2020c) defined play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (para. 2). Because of its responsiveness to children's unique, developmental needs, play therapy has gained favor among counselors (Pereira & Smith-Adcock, 2013; Ray et al., 2005; Shin & Gonzalez, 2018).

Landreth et al. (1999) affirmed that it is not sufficient to adapt counseling skills used with adults for counseling children. The authors argued that counseling children takes a specific and unique set of competencies. Further, most counselors, at some point in their career, will counsel children (Lawrence & Kurpius, 2000; McNary et al., 2019). Landreth (2012) declared that children are not miniature adults. Landreth (2012) noted, "Toys are the child's words, and play is their language" (p. 12).

Play therapy is a method that counselors use to counsel children with the use of toys in a therapeutic setting such as a playroom (Schaefer, 2011). This empirically founded method is firmly grounded in theory and appeals to young children. Play therapy emphasizes the importance of the relationship between the counselor and the child (Axline, 1947). Although it can be implemented through various modalities, generally the modality of choice is one-on-one, individual sessions to build a strong therapeutic alliance (Schaefer, 2011).

Counselors who implement play therapy use a well-stocked playroom with carefully selected toys that match the developmental level of children in a therapeutic milieu (Ray et al., 2015). Toys are to be selected, not collected, so that careful attention is given to exploration of real-life experiences, nurturing, sensory engagement, creative expression, and aggressive play (Landreth, 2012). Toys are to be displayed with easy access for children at their level. Real-life toys can include a doll house, doll family, puppets, cars, and money. Nurturing toys include items such as a doctor kit, baby dolls, and stuffed animals. Sensory engagement items include play dough, kinetic sand, sand trays, and squishy toys. Creative expression items can be blocks, paint, musical instruments, and dress-up items. Aggressive play involves a bop bag, toy soldiers, and egg cartons for destroying. Sensitivity to culture and diversity in toy selection must be considered, as well (American Counseling Association, 2014; Landreth, 2012; Schaefer, 2011).

The literature suggested that the playroom allows copious opportunities for children to resolve conflict, express themselves symbolically, learn new ways of coping, gain mastery over the environment, express feelings, and reveal their psyche (Jayne & Ray, 2015; Ray et al., 2015; Van Velsor, 2004). Children learn a great deal about themselves secondary to being unconditionally accepted by the counselor during meaningful play (Jayne & Ray, 2015). Without instruction, children explore and orient themselves to the world through play that helps them understand time, space, people, places, and things.

Various theories serve to inform the counselor in the practice of play therapy, such as child-centered, gestalt, cognitive behavioral, Adlerian, Jungian, relational-cultural, and reality choice theory (Davis et al., 2015; Green et al., 2013; Landreth, 2012; Meany-Walen et al., 2015; Oaklander, 2001; Stulmaker & Ray, 2015; Vicario et al., 2013). Counselors use theory as a framework to guide their practice (Schaefer, 2011). The theory utilized by the counselor helps to

direct the sessions toward optimal growth based on the needs of the child. By systematically using a theoretical model, counselors establish an interpersonal process through play that has been proven effective with children (APT, 2020c).

Each theory has a different approach to the play therapy session (Schaefer, 2011). Child-centered theory is focused on the child taking the lead, with the counselor not asking questions but instead using tracking and reflecting (Landreth, 2012). Gestalt centers on the whole child with more active approaches using the senses, such as clay work, storytelling, and artist expression (Oaklander, 2001). CBT helps the child be aware of thinking that affects behaviors (Knell & Moore, 1990). In Adlerian play therapy, the counselor gets down on the ground and plays with the child to improve interpersonal skills and connectedness (Kottman, 2003). Jungian work includes mandala and sand trays to bring symbolic awareness to the forefront (Green et al., 2013). A mandala is a round "sacred circle" that represents wholeness and integration of the psyche. Sand trays are used to explore the psyche by creating scenes in the sand with miniature toys. Relational-cultural play therapy reestablishes healthy connections, particularly for children exposed to trauma (Vicario et al., 2013). The focus is on growth-fostering relationships (Miller, 1976). Reality choice is based on universal tenets such as the need for survival, love, belonging, freedom, fun, and power (Glasser, 2000). Selecting a theoretical approach helps to guide the session in the playroom (Schaefer, 2011).

Trained counselors knowledgeable in play therapy must learn to integrate the many components of play therapy methods to enhance effectiveness of treatment (Landreth, 2012). These components continue to extend in application with an interesting history. This history dates back to the beginnings of Sigmund Freud's psychoanalytic theory (Schaefer, 2011). The development of play therapy began in the early 1900s, and perhaps even earlier, and continues to

the present day. Rousseau, in the 18th century, wrote about the importance of observing a child's play to learn about the child (Landreth, 2012). Aristotle (384–322 B.C.) is known to have compared play to the highest form of research among youth (APT, 2020h). Influential minds, throughout the ages, have focused on play.

History of Play Therapy

Play therapy has its origins in the psychoanalytic work of Sigmund Freud in the early 1900s (Schaefer, 2011) as it pertained to his work with Little Hans. This was the first published case of using play in therapy for children (Landreth, 2012). According to McLeod (2016) and Schaefer (2011), Freud posited that play performs three functions in the lives of children: to promote self-expression of that which is taboo, to fulfill wishes, and to master traumatic events. Psychoanalyst Melanie Klein continued this framework but added miniatures or small toys while working with children (Schaefer, 2011). Margaret Lowenfield then expanded the idea of working with miniatures in the late 1930s and developed the world technique. This technique used a sand tray for imaginative play to create a view into the child's psyche. Anna Freud was another psychoanalyst who used play in therapy sessions with children in the 1940s. She brought child psychotherapy into the forefront with a strong focus on the child–therapist relationship (Schaefer, 2011).

The groundbreaking work of Virginia Axline (1947) provided the origins of nondirective play therapy in the field of counseling with a more humanistic focus (Schaefer, 2011). This type of therapy was founded on the belief that children possess the ability to make meaning of their experiences and solve their own problems in a milieu of unconditional positive regard, empathy, and authenticity (Rogers, 1951). Landreth (2012) noted much of this approach was based off the

work of Carl Rogers (1951). Virginia Axline, a student and later colleague of Carl Rogers, became instrumental in developing nondirective play therapy.

Axline (1947) effectively operationalized the principles of Rogers's nondirective person-centered theory for application in relationships with children in play. Rogers's (1951) theory was that people are self-directed and always moving toward self-actualization. A counseling relationship characterized by empathy, congruence, and unconditional positive regard is necessary for a client to reach self-understanding (Rogers, 1951). Eventually, the client matures toward self-actualization without the need for direction from the counselor. This process occurs within the nondirective principles for child-centered play therapy that Axline (1947) established. Axline's eight basic principles are the following:

- The therapist must develop a warm and friendly relationship with the child.
- Accept the child as they are.
- Establish a feeling of permission in the relationship so that the child feels free to express their feelings completely.
- Be alert to recognizing feelings the child is expressing and reflect these feelings back so the child gains insight into their behavior.
- Maintain a deep respect for the child's ability to solve their problems and give the child the opportunity to solve problems, so the responsibility to make choices and institute change is within the child.
- Do not attempt to direct the child's actions or conversation in any manner; the child leads the way. and the therapist follows.
- Do not rush the therapy; it is a gradual process and must be recognized as such by the therapist.

- Only establish those limitations necessary to anchor the therapy to the world of reality and to make the child aware of their responsibility in the relationship.

Since 1970, play therapy has progressed under the leadership of seminal minds such as Schaefer (2011), Landreth (2012), Kottman (2003), Oaklander (2001), and others. Two major developments in the field that have contributed to professional development and training are the national Center for Play Therapy (2020) and the APT (2020a). These institutions have served to professionally advance the method of play therapy nationally and internationally.

A national center for play therapy was established at the University of North Texas in Denton by Dr. Garry Landreth in 1988 (Center for Play Therapy, 2020; Landreth & Bratton, 1999). Dr. Emily Oe was Dr. Landreth's part-time, voluntary secretary during the establishment (G. Landreth, personal communication, March 25, 2020). The Center for Play Therapy provides training, practice, and supervision in play therapy for graduate students and practicing professionals from the United States, Canada, Mexico, China, and other countries. A 6-day summer institute is offered annually at the University of North Texas, facilitated by leaders in the field. A 4-day intensive supervision program is also offered each summer. These trainings attract experts in the field of play therapy from around the world.

The APT is a professional membership organization established to advance play therapy (APT, 2020a). The organization is interdisciplinary, eclectic, and international in orientation (Landreth, 2012). Along with numerous benefits to members, the organization outlines best practices regarding competencies in play therapy (Schaefer, 2011). These efforts ultimately provide preparation that is most developmentally appropriate for counseling children (Ryan et al., 2002). APT also strives to continue research, advocate for more diversity, provide excellent development of counselors through continuing education, promote acceptance of

developmentally appropriate interventions or methods, and work with universities to offer play therapy coursework as part of the counselor education curriculum (Ryan et al., 2002). APT (2020a) has served as a means of promoting play therapy in the field of mental health counseling since 1982.

Professional Development in APT

The APT (2020a, 2020b, 2020e, 2020f, 2020g) provides membership, credentials, continuing education, conferences, leadership academies, research, and publications. Counselors who are interested in play therapy have APT resources available to help guide them in providing the method. The CACREP (2016) encourages active membership and involvement in professional counseling organizations that contribute to personal and professional growth. APT (2020i) offers numerous and varied opportunities for professional development and growth.

The APT provides conferences at the national and state levels; webinars; and self-study through books, materials, and DVDs (APT, 2020i). Workshops are offered by Registered Play Therapists and other qualified professionals. The types of APT-approved education include the APT e-learning center, continuing education workshops online, approved centers of play therapy, education opportunities, university coursework, and approved providers of continuing education. All of these offerings contribute to the continuing education for counselors. The leadership academy has been established to orient mental health professionals toward leadership attributes that advance play therapy and the organization. The academy is a 5-month program that prepares interested members in leadership for APT.

The *International Journal of Play Therapy* and *Play Therapy Magazine* are reputable publications also offered by the APT (2020e). Research and publication are highly encouraged to ensure best practices in the field. The APT also offers an evidence-based practice statement with

an identified population of children 3–13 years of age (Ray & McCullough, 2016). The research included meta-analyses, randomized control trials, observational studies, qualitative studies, and case reports. This evidence-based statement advised on the effectiveness, evaluations, quality, and application of play therapy. The recommendation by the organization is for children 3–13 years of age to participate in play therapy to reduce symptoms related to behavioral and emotional problems toward healthy development. The statement indicated the effectiveness of play therapy. The APT researchers also emphasized the need to appropriately evaluate the level and application to be used as a mental health intervention (Ray & McCullough, 2016).

History of APT

The APT was established in 1982 by Charles Schaefer and Kevin O'Connor (Landreth, 2012) to advance the use of play in therapy for professionals around the world who value the use of methods that are developmentally appropriate (APT, 2020a). The mission of the organization is to promote the value of play, play therapy, and credentialed play therapists. The APT (2020a) provides public understanding and appreciation of play therapy, promotes the effective practice of play therapy, recognizes diversity, and maintains a strong professional organization that satisfies the mission. Additionally, state branches are focused on play therapy under the auspices of APT. The national office is located in Clovis, California.

Other professionals who made contributions to the organization and are currently a director emeritus include Charles Schaefer, Kevin O'Connor, Linda Homeyer, Louise Guerney, Garry Landreth, and Lessie Perry (APT, 2020a). These professionals provided distinguished service as former members of the APT board of directors. They continue to serve in developing the organization for mental health professionals who apply the therapeutic power of play in counseling. Under their leadership, membership has grown from 450 in 1988 to over 5,670 in

2011 (Landreth, 2012). Over the years, various governance committees have been established in the APT (2020a), including conference programming, research, university education, continuing education, and ethical practices. The ethics and practices guidelines committee members work to keep practitioners updated on pertinent ethical and legal issues.

Ethics in APT

The APT promotes ethical practices in the guidelines but does not act as an ethics regulatory body (Carnes-Holt et al., 2016; Ray & McCullough, 2016). Instead, the APT requires members to adhere to codes of ethics promulgated by their licensing boards or certifying authorities in their respective states. Members are, therefore, affiliated with their state regulating ethical and legal requirements (Carmichael, 2006). Professional counselors and school counselors who use play therapy also may be affiliated with professional organizations such as the American School Counselor Association (2020) or the American Counseling Association (2014). Play therapy involves counseling minors, which poses a unique set of ethical dilemmas, and thus an ethical decision-making model is essential (Carmichael, 2006; Carnes-Holt et al., 2016).

The use of an ethical decision-making model provides the counselor with a strategic and normalizing approach for difficult decision-making. Carnes-Holt et al. (2016) recommended an eight-step ethical decision-making model developed by Wheeler and Bertram (2019) for play therapists. The steps are as follows (Wheeler & Bertram, 2019):

1. Define the problem, dilemma, and subissues.
2. Identify the relevant variables.
3. Review or consult the law, ethics codes, and institutional policy.
4. Be alert to personal influences.

5. Obtain outside perspective.

6. Enumerate options and consequences.

7. Decide and take action.

8. Document decision-making and follow-up actions.

Currently, renewal of credentials with APT does not require continuing education hours in ethics (APT, 2020b; Carnes-Holt et al., 2016). Mental health professionals are assumed to receive their ethics requirements under their licensing board requisites. Utilizing methods based on rigorous research not only gives credibility to competence but also assists in protecting counselors against litigation (Carmichael, 2006; Homeyer & Morrison, 2008). The APT (2020b, 2020c) has encouraged play therapists to practice within their boundaries of competence, relevant training, experience, and supervision. Offering credentials as a Registered Play Therapist, Registered Play Therapist-Supervisor, and School Based-Registered Play Therapist, therefore, increases credibility of the profession and gives practitioners recognition as experts who work with children by supporting advanced competence in play therapy (Kottman, 2003).

Credentialing in the APT

The APT (2020b) has instituted professional standards that must be met prior to receiving the credentials of Registered Play Therapist, Registered Play Therapist-Supervisor, and School Based-Registered Play Therapist. These credentials are not licensures or certifications but provide documentation that a play therapist has met minimal training and supervised experience standards (Carmichael, 2006). These requirements have been established to maintain a high professional standard acknowledging those trained in play therapy methods; consequently, all professionals credentialed must provide applicable continuing education. These credentials are

renewed annually through APT. Following credentialing, 18 hr of APT-approved continuing education are required every 3 years (APT, 2020b).

The standards for a Registered Play Therapist include (a) a master's degree or higher and a state license in counseling, psychology, social work, or a respective mental health field; (b) academic coursework in child development; theories of personality; principles of psychotherapy; child and adolescent psychology; and legal, ethical and professional issues; (c) a current, active, and unconditional state license to provide clinical mental health services; (d) completion of 150 hr of specific training in play therapy history, theories, techniques or methods, and applications to special settings and populations; and (e) completion of 350 hr of supervised play therapy experience and 35 hr of play therapy supervision, under the supervision of a Registered Play Therapist- Supervisor (APT, 2020b). Applicants for the Registered Play Therapist-Supervisor credential must hold the Registered Play Therapist credential for 3 years in good standing and then complete the following requirements: (a) an additional 3 years and 3,000 hr of clinical experience, (b) approval by the state mental health board to supervise, (c) an additional 500 hr of play therapy experience, and (d) at least 6 hr of additional supervisor training (APT, 2020b). Registered Play Therapist-Supervisor applicants must compete 24 hr of clinical supervisor academic instruction if not already fulfilled by the state mental health board for supervision. Play therapy supervisors are in a unique position to develop Registered Play Therapists in the mastery of attitudes, knowledge, and skills needed; evaluate the supervisee's competence effectively; and promote professionalism in the field (Thanasiu et al., 2018).

Criteria for the credential of School Based-Registered Play Therapist include (a) a current and active state license or certificate from the state department of education to practice as a school counselor or school psychologist; (b) a master's degree or higher in mental health; (c)

completed coursework in child development, theories of personality, principles of psychotherapy, child and adolescent psychopathology, and ethics; (d) clinical experience required by the state department of education for school counselor or school psychologist license or certification plus 2 years of continuous work in the school setting certification; (e) 150 hr of play-therapy-specific instruction from higher education or approved providers; and (f) supervision by a Registered Play Therapist-Supervisor for no less than 1 school year with a minimum of 600 hr of direct client contact in play therapy plus 50 hr of simultaneous supervision (APT, 2020b). The School Based-Registered Play Therapist credential requires 3 hr of training on the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) in addition to the 18 hr in play therapy continuing education.

The requirements for the Registered Play Therapist-Supervisor credential are the most stringent, compared to the Registered Play Therapist and School Based-Registered Play Therapist credentials (APT, 2020b). The scope of what counselors can do with the credentials is different as well. The Registered Play Therapist-Supervisor is able to supervise counselors who are working toward becoming Registered Play Therapists (Ryan et al., 2002). School counselors who hold the School Based-Registered Play Therapist credential are only able to practice in the school setting (Hudspeth, 2016). The Registered Play Therapist is able to practice under their license as a professional counselor (APT, 2020b). The various requirements are suited for how and where the counselors are able to use their credential. The difference in the training requirements is a salient point to note.

Counselors have an obligation to claim only certifications or credentials that are in current and good standing (American Counseling Association, 2014). Mental health professionals who hold play therapy credentials must have not only quality training in methods

of play but also a strong understanding of children's social, emotional, and psychological development (APT, 2020b, 2020c). They also may not hold more than one APT credential at a time. Counselors are ethically bound to provide treatments that are most effective (American Counseling Association, 2014), including treatments designed to meet children's unique needs. When counselors are trained in play therapy, they learn to view children differently, scrutinize their attitudes about children and play, construct new knowledge about how to counsel children, and put new skills into practice (Henriksen, 2006).

Transformational Learning Theory

Transformational learning theory is an andragogy that provides a theoretical lens to inform counselor educators (Fazio-Griffith & Ballard, 2016) regarding construction of new knowledge that can be applied in practice. This theoretical lens borrows from Rogers (1980) and can be expressed as a description of how learners reformulate meaning from their educational experiences. Transformational learning theory purports that adults learn best when their frame of reference is challenged (Fazio-Griffith & Ballard, 2016). The relationship that develops in training counselors in play therapy is influential for the learner to reconstruct worldviews. This training experience is, therefore, transformational. The CACREP (2016) standards addressed the need for purposeful and meaningful strategies for instruction that encourage insight, particularly in regard to helping relationships.

Transformational learning theory (Mezirow, 2004) values not only knowledge but also increased attitudes, values, beliefs, and skills in the topic (Fazio-Griffith & Ballard, 2016). Core methods offer practical application for implementation (Fazio-Griffith & Ballard, 2016):

- Establish a shared vision.
- Provide modeling and mastery experiences.

- Intellectually challenge and encourage the learner.
- Personalize attention and feedback.
- Create experiential lessons that transcend the training.
- Promote ample opportunities for reflection.

In counselor education, transformation learning theory serves to increase positive counseling outcomes for all people (Henriksen, 2006). This is particularly true for preparation programs, because the intent is to change or expand paradigms of thinking and functioning for students (Muro et al., 2015). Counselor educators who use transformational learning theory challenge students' perspectives in a humanistic manner (Rogers, 1951). Those who provide training in the method of play therapy for counselors offer similar challenges (Landreth, 2012). Actual changes take place as counselor educators, counselors, and counseling graduate students develop an in-depth understanding of attitudes, knowledge, and skills needed to provide play therapy (Henriksen, 2006). These attitudes and skills, then, become internalized concepts that are part of who the counselor is as a person (Rogers, 1980).

Counselor educators, counseling students, and counselors question paradigms, think and act collaboratively, experiment to understand problems, and continue high-level reflection in transformational learning theory (Yukawa, 2015). Transformational means understanding results within shifting perspectives. The learner makes an action decision based on insights gained (Mezirow, 2004) during the transformation. Being capable of change is, therefore, central to transformational learning. As much of what is learned in counselor education requires examining values, change can become delicate territory (Henriksen, 2006).

Knowledge construction means that new knowledge focuses on different ways of doing things or different ways of counseling (Henriksen, 2006). The instruction moves from content

integration to knowledge construction in transformational learning theory. What is learned can then be used in direct application in the active work of counseling (Muro et al., 2015). As a result of implementing transformational learning theory into counselor preparation, counselors and graduate students learn existential and humanistic ways of understanding the client's existence (Henriksen, 2006). Mezirow (2004) aligned development and learning together in a positive, growth-oriented manner. The developed adult transforms into a differentiated person with a flexible view of humanity. The adult learner must be able to reflect critically upon experiences and hold a rational discourse with others (Mezirow, 2004).

Mezirow (2004) described critical reflection upon experiential learning as part of intellectual growth. He denoted three types of reflection: content reflection, process reflection, and premise reflection. Content reflection is thought on the actual experience, whereas process reflection is thought on handling the experience. Premise reflection examines assumptions, beliefs, and values on thought. In addition to reflection, the learner must hold a rational discourse with others about these new meanings to test the functionality. Rational discourse is done by bracketing schema, bias, and prejudice. Since this process can only be done in formal operational thinking or higher levels of cognitive functioning, graduate students and beyond are ideal for the use of transformational learning theory (Merriam, 2004).

Echoing this premise, Landreth (2012) recommended a system for counselor education in regard to play therapy training. Landreth (2012) purported that graduate students receive content areas of study for knowledge in child development, counseling theories, clinical counseling skills, and play therapy instruction. He advised that students observe and conduct case analyses on adaptive and maladaptive children. Once completed, students can observe experienced play therapists to discuss and evaluate their sessions. Finally, students experience supervision while

conducting play therapy sessions (Landreth, 2012; Muro et al., 2015). Landreth (2012) also recommended the use of role play and working in dyads for play therapy training. Until more universities offer play therapy coursework, however, some of these requirements have to be fulfilled by workshops and intensive institute training (Landreth, 2012).

Play Therapy Training of Counselors

The American Counseling Association (2014) code of ethics addressed professional competence by stating that counselors practice only within the boundaries of their competence based on their education and training. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work. Most counselors do not receive adequate training at the university level in providing play therapy (Lambert et al., 2007; Ray et al., 2005; Van Horne et al., 2018) or little, if any, therapy training for children, which becomes an ethical issue (Shen, 2016). Therefore, counselors utilize workshop training and intensive institutes to receive the training needed to implement play therapy (Pereira & Smith-Adcock, 2013; Perryman et al., 2017; Shin & Gonzalez, 2018; Van Horne et al., 2018).

As play therapy is an approach to counseling that requires special skills, training is necessary (Kottman, 2003; Landreth, 2012; Muro et al., 2015). Landreth (2012), world-renowned for his work in child-centered play therapy, emphasized the importance of training to ensure that children receive quality help from competent therapists. Kottman (2003), known for her work in Adlerian play therapy, stated that counselors use toys, art, and other media to communicate with children in specialized ways. Landreth (2012) and Kottman each elucidated that to become a play therapist, counselors must learn a foundation of theory and techniques under the supervision of a highly trained play therapy supervisor. The supervisor provides specific expertise as the counselor learns to understand children's symbolic, metaphoric

communication based on patterns and themes (Lindo, Meany-Walen, & Sullivan, 2012). Examining actual types of training and the evaluations of play therapy attitudes, knowledge, and skills is thus important.

Play Therapy Training Evaluation of School Counselors

Four studies evaluated the effectiveness of training in play therapy as it related to attitudes, knowledge, and skills for school counselors (Kagan & Landreth, 2009; Ray et al., 2005; Shin & Gonzalez, 2018; Van Horne et al., 2018). One qualitative study assessed workshop training for elementary school counselors (Shin & Gonzalez, 2018). The other three published studies were quantitative in design. In these studies, Kagan and Landreth (2009) examined their 2-day, short-term play therapy training program, Ray et al. (2005) looked at play therapy practices of elementary school counselors, and Van Horne et al. (2018) studied factors related to use of play therapy among the school counselors. A quantitative pilot study completed prior to this research project by the principle researcher (Anderson, 2019) examined correlations between types of training and attitudes, knowledge, and skills in play therapy among elementary school counselors. The results of this pilot study are also included in this section.

Shin and Gonzalez (2018) conducted a qualitative evaluation of their workshop training in play therapy for elementary school counselors. The researchers developed a 1-day, 8-hr workshop using child-centered play therapy based on Bratton et al.'s (2006) treatment manual on child parent relationship therapy. The contents of the workshop included training on play therapy techniques, theoretical approaches, play therapy development, and toy selection. Constructivism was used as a guide for the research study.

Six participants attended the intensive training at a university in the southern United States. The data were collected over 2 months by recording one-on-one, in-person interviews

(Shin & Gonzalez, 2018). The researchers held preinterviews, posttraining interviews, and a follow-up. In the qualitative analysis, Shin and Gonzalez (2018) reviewed the tapes, coded pertinent information, located themes, used a constant comparative technique, and explored the participants' experiences and perceptions for individual meaning making so that all voices were heard. Trustworthiness was established with the use of peer review and member checking.

Shin and Gonzalez (2018) found two main themes in data analysis of transcribed interviews: (a) professional school counselors changed their perceptions after the 1-day, 8-hr workshop, and (b) the counselors valued the experience of participating in the workshop. A critical finding of the study was that the training improved self-perceived competencies. The project provided unique data in regard to school counselors' improved attitudes, knowledge, and skills in play therapy after receiving workshop training.

Kagan and Landreth (2009) conducted a quantitative evaluation of their play therapy training program. An experimental study in northern Israel involved school counselors and teachers to examine whether a 2-day short-term intensive training on child-centered play therapy would have a positive effect on play therapy attitudes, knowledge, and skills of those receiving the treatment. The experimental group consisted of 18 participants who graduated from a counseling or education-related university program, were currently working with children, agreed to participate in the 15-hr play therapy training, and consented to taking the survey. The control group was comprised of 15 volunteer participants with the same academic and practical background. Training for the treatment group included lectures, discussion, and role play. All participants were given the PTAKSS before and after training.

Treatment participants' results showed no statistically significant increase ($p = .22$) in play therapy attitude, which Kagan and Landreth (2009) attributed to Israeli culture and language

being less receptive to self-introspection and nondirect ways of speaking. Play therapy knowledge results showed a statistically significant positive increase ($p = .03$) as indicated on scores of the PTAKSS knowledge subscale for the treatment group. The alpha level was set at the .05 level. No statistically significant change ($p = .38$) was noted in the skills subset for those in the control group. The authors concluded that play therapy knowledge was positively affected by the short-term training on child-centered play therapy for Israeli teachers and school counselors. Kagan and Landreth suggested that long-term training would produce more positive results.

Van Horne et al. (2018) studied factors related to the use of play therapy among elementary school counselors. The authors explored counselor factors of age, experience, workshops in play therapy, graduate courses in play therapy, hours and months in supervision, school counselor efficacy, and perceived effectiveness using play therapy. The sample was 192 practicing counselors across the United States who were members of the American School Counselor Association. The counselors completed the Elementary School Counselor Play Therapy Survey, which consisted of 24 questions related to the factors explored.

The results indicated that 57% of the counselors used play therapy and 42% did not use play therapy at school (Van Horne et al., 2018). Only 29% of the counselors had taken a graduate-level course in play therapy. The mean number of continuing education credits received in play therapy was 16.8 hr. The counselors in the sample had little training overall. Further, only 18% of the counselors received supervision in play therapy. The results indicated that education, training, and supervision were not related to use of play therapy. Perceived effectiveness using play therapy was the only factor related at a statistically significant level to actual use for school counselors (Van Horne et al., 2018). How counselors achieved this perceived effectiveness,

however, was unclear and an area worth exploring further. Van Horne et al. (2018), nonetheless, acknowledged the implications of the School Based-Registered Play Therapist credential to help address issues of training and supervision for school counselors effectively using play therapy.

Ray et al. (2005) conducted a quantitative study on the play therapy practices of elementary school counselors. These school counselors were also members of the American School Counselor Association. Participants were surveyed regarding play therapy training, practice, beliefs about play therapy, and perceived limitations. The name of the survey was not given, but it was based on Axline's (1947) basic principles of play therapy. Psychometrics were neither mentioned in the instrument section nor listed as a limitation, which was a concern. The sample size in this study, however, was a robust 381. The following research questions guided the study: What is the relationship between counselors' type of play therapy training and the use of play therapy in the schools? What is the relationship between counselors' beliefs in play therapy and the use of play therapy in the schools? What is the relationship between counselors' perceived barriers to using play therapy in the schools and the use of play therapy in the schools?

The counselors who were surveyed reported that they believed in the utility of play therapy in the schools (Ray et al., 2005). The reason given was that play therapy is a developmentally appropriate approach for young children. Lack of time and lack of training in play therapy were reported by counselors as the primary problem; 67% had not taken even one university course in play therapy. Chi-square tests revealed a significant relationship between formal training in play therapy and the use of play therapy. The study supported the need for more play therapy training for future school counselors.

I conducted a quantitative pilot study to begin examining the relationship between various types of training and attitudes, knowledge, and skills in play therapy among elementary

school counselors (Anderson, 2019). The study was completed in the fall of 2019 at St. Mary's University under the supervision of Dr. Dan Ratliff, professor of counseling, as part of this doctoral research project. Through email, I recruited 200 elementary school counselors from four urban/suburban school districts in the Austin and San Antonio region to complete the PTAKSS-R (Kao, 2009) as an anonymous, online survey. Of the surveys sent, 21 school counselors completed the PTAKSS-R.

The independent variable was types of training in play therapy, including workshops, institutes, conference training hours, and university coursework (Anderson, 2019). The dependent variable was attitudes, knowledge, and skills in play therapy. When frequencies were run for each category, of the 21 respondents, 7 had university training, 6 had institute or conference training hours, 5 had workshop training, and 11 had no training in play therapy. Few counselors had adequate training in play therapy. Among the sample, those who had taken university coursework in play therapy showed a positive correlation (r = .547) with the knowledge subset. A strong positive correlation (r = .923) was found between overall knowledge and skills in play therapy.

The pilot study, *Attitudes, Knowledge, and Skills of Play Therapy Among Elementary School Counselors,* indicated that university-level training in play therapy related most closely to the knowledge that school counselors have about play therapy (Anderson, 2019). Those who had taken university coursework in play therapy showed increased knowledge compared with those who received other forms of training. Most school counselors in the sample reported a positive attitude towards children and play therapy. On a 1–5 Likert scale, the mean for the attitudes scale score was 4.39, for knowledge scale score was 2.93, and for the skills scale score was 2.95. The study showed that school counselors with little or no training had equally positive attitudes

toward play therapy, indicating a possibility of professional development in play therapy for school districts in the sample. The data suggested that the more knowledge a counselor has in play therapy, the more confidence the counselor will have in play therapy skills. From the pilot study, I planned to use a regression analysis in the dissertation research study to see if knowledge predicts skills in play therapy.

A limitation of the pilot study was the small sample size (Anderson, 2019). The dissertation study needed a larger sample to contribute to generalization of the findings. Various ways that I considered recruiting participants for the dissertation research project included drawing from the APT (2020d) roster and possibly reaching out to counselor groups on social media. This networking and outreach could make the next study more robust in producing results that are generalizable (see Babbie, 2013).

Play Therapy Training Evaluation of Professional Counselors

Other research found on play therapy training focused on mental health counselors (Carnes-Holt & Weatherford, 2013; Lambert et al., 2007; Ryan et al., 2002). One study related to professional counselor training in play therapy and attitudes, knowledge, and skills in play therapy (Carnes-Holt & Weatherford, 2013). In the other two studies, researchers were interested in how professional organization membership in the APT related to specific variables such as training, supervision, professional identity, play therapy modalities used, and employment setting (Lambert et al., 2007; Ryan et al., 2002). Neither of these studies involved an examination of counselors' attitudes, knowledge, and skills in play therapy as related to membership in the APT.

Carnes-Holt and Weatherford (2013) studied intensive play therapy training for rural mental health counselors in a quantitative evaluation. They provided a 2-day play therapy training session as a potential model for best practice. The training session was facilitated by a

licensed professional counselor credentialed as a Registered Play Therapist-Supervisor. The participants were five women who were employed in the area and provided mental health services to children. The PTAKSS was administered pretest, midpoint, and posttest to participants. As the sample size was small, the survey results were analyzed in Predictive Analytics Software Statistics for descriptive statistics with paired-sample *t* tests. Statistical results were not significant, but they were not expected to be considering the limitations of the study.

The results gave a snapshot of participants' attitudes, knowledge, and skills in play therapy (Carnes-Holt & Weatherford, 2013). Data also supported a best practice model indicating growth in knowledge and skills in play therapy. The small sample size and inability of two of the participants to return for a 2nd day of training due to inclement weather were severe limitations of the study. The relevance of the study was that it demonstrated the challenges rural mental health providers encounter. Carnes-Holt and Weatherford (2013) highlighted the need for mental health professionals to receive play therapy training in rural settings. They specifically expressed lack of training as a problem. The authors claimed that training in research-based methods such as play therapy supports a system of care for children.

Lambert et al. (2007) organized a quantitative study comparing mental health providers who are members of the American Counseling Association with those who are members of the APT regarding play therapy training and continuing education units, among other factors. Some of the other factors included professional identity, play therapy modalities used, and employment setting. Professional counselors who responded constituted 45% of the sample. School counselors who responded were 9.8%, and social workers were 20.5% of the sample. Other mental health professionals who completed the survey were marriage and family therapists,

psychologists, counselor educators, rehabilitation counselors, and substance abuse counselors. The total number of participants in the study was 958.

Lambert et al. (2007) assessed training by asking respondents about the amount of play therapy coursework and continuing education units that were received in total. The overall average number of play therapy courses taken in graduate school was 1.5 (SD = 1.9). No statistically significant difference was found between mental health professionals who belonged to the American Counseling Association only, the APT only, or both associations in the other factors. However, a significant difference was found in the amount of continuing education received by these groups. The researchers' hypothesis was tested by comparing (a) those who belonged to the American Counseling Association only and (b) those who had membership in the APT or both memberships. The APT group and group with both memberships were combined because the continuing education units reported by both groups were similar.

A Mann–Whitney U test was conducted to compare groups (Lambert et al., 2007). The hypothesis test demonstrated that the groups were statistically different (U = 6899, $p < 0.001$). Play therapists with membership in the APT obtained between 88.29 and 118.64 more continuing education units in play therapy than their American Counseling Association counterparts. The results indicated that APT membership made a difference in the amount of continuing education or training the received in play therapy. Though the study highlighted training and membership, Lambert et al. did not measure the relationship of APT membership with attitudes, knowledge, and skills in play therapy.

Ryan et al. (2002) surveyed members of the APT regarding educational background, continuing education, supervision, work settings, and distribution of play therapy in their workload. The sample of 891 provided information across the specific variables. Descriptive and

inferential statistics were used to explore the characteristics and attributes of these counselors. The majority of respondents expressed the desire to obtain more skill development. Approximately 40% received some graduate coursework in play therapy. A correlation was found between the number of workshop hours in play therapy and both membership status, $r(840) = .51$, $p < .001$, and membership years, $r(840) = .43$, $p < .001$. Further, 87% of participants expressed wanting to attend more play therapy training on special topics. Again, the researchers did not measure the relationship of APT membership with attitudes, knowledge, and skills in play therapy.

Play Therapy Training Evaluation of Counseling Graduate Students

Most of the research findings in the literature were in regard to play therapy training for graduate counseling students (Dillman Taylor et al., 2017; Flasch et al., 2017; Kao & Landreth, 1997; Lindo, Chung, et al., 2012; Lindo, Meany-Walen, & Sullivan, 2012; Muro et al., 2015; Pereira & Smith-Adcock, 2013; Smith-Adcock et al., 2012). Two of these were quantitative studies to evaluate graduate counselor education students' perceptions after taking an introductory course in play therapy (Flasch et al., 2017; Kao & Landreth, 1997). In an additional quantitative study, Muro et al. (2015) explored school-based play therapy training at the graduate level. One study was a quasi-experimental evaluation of a workshop-based course in play therapy (Pereira & Smith-Adcock, 2013). In another study, researchers utilized a mixed-method approach examining the impact of training on child-centered play therapy in an introductory course on graduate students' attitudes, knowledge, and skills in play therapy (Lindo, Chung, et al., 2012). Finally, researchers in two qualitative studies evaluated coursework in a play therapy class (Dillman Taylor et al., 2017; Smith-Adcock et al., 2012).

Flasch et al. (2017) evaluated graduate-level counselor students' perceptions of counselor competence and comfort with play therapy after completing an introductory course. The researchers designed the quantitative study to gain perspectives from counseling students who were anticipating their work with children and adults. They utilized a pretest–posttest design to evaluate self-perceived competence and comfort using play therapy techniques and interventions. The course was a 1-week, 40-hr, intensive training experience. To conduct course evaluations, the researchers created the Play Therapy Comfort and Competency Survey in which participants self-rated on a 5-point Likert scale. Since the instrument was created by Flasch et al. for the study, psychometric information was not available to gauge whether the survey was sound. This was not mentioned in limitations, which was a serious concern.

The pretests and posttests were gathered and matched for all 37 participants. Flasch et al. (2017) used analysis of variance (ANOVA) to compare group means in the following categories:

- overall change,
- comfort with play therapy interventions with children,
- comfort with play therapy interventions with adults,
- knowledge and understanding of specific play therapy techniques and interventions,
- comfort using play therapy with different age groups,
- comfort using play therapy with diverse populations, and
- comfort using play therapy to address various diagnoses based on the *Diagnostic and Statistical Manual of Mental Disorders*.

Participants' self-perceived competence and comfort levels were higher after taking the course (Flasch et al., 2017). Self-perceived competence varied depending on the topic. As the course emphasized play therapy with children, the largest percentage of students (n = 37; 100%)

reported improvement in self-perceived competence using play therapy with children. Participants also reported high levels of self-perceived competence in specific play therapy interventions (*n = 35*; 94.6%).

Flasch et al. (2017) reported that they hoped to use findings to inform future additional play therapy courses. The structure of the course, a 1-week intensive training, appeared to be effective at increasing this group of students' competence and comfort with children. Though Flasch et al. stated the results were at a statistically significant level for all groups, *p* values were not presented in the tables. Limitations of the study were that the findings were not generalizable because the sample size was small and only one class setting. The researchers did not acknowledge the lack of an established instrument as a limitation. The authors instead considered practical significance to find meaning from the results.

Kao and Landreth (1997) designed a quantitative study to determine effectiveness of a play therapy course for beginning graduate students. This landmark study was conducted at the University of North Texas. The purpose of the study was to test the students' self-reported attitudes, knowledge, and skills in play therapy after taking an introductory course. The PTAKSS, developed by the authors, was the instrument utilized. Kao and Landreth also measured the trainees' intellectual efficiency, based on verbal fluency and dominance. The instrument used for this was the California Psychological Inventory. The experimental study included an experimental group of 37 and a control group of 29.

The results of the study showed a significant increase in attitudes, knowledge, and skills after play therapy training (Kao & Landreth, 1997). The dominance score in the experimental group showed a significant decrease, indicating that the students learned to allow the child to lead rather than themselves. Intellectual efficiency also showed a decrease, as indicated by scores

on the California Psychological Inventory. Though this decrease seemed to be an adverse effect, it actually demonstrated that the trainees became less verbally expressive, thus allowing the child to self-express more fully. Additionally, the authors stated that the decrease might have resulted because students are learning a more nondirective pattern of communication. The conclusion was that the training on child-centered play therapy had a positive effect on graduate students, who learned to be more supportive and less dominant.

Muro et al. (2015) explored school-based play therapy training that included service learning within an elementary school for counseling graduate students. In the quantitative study, the researchers administered the PTAKSS-R to 13 students across three time periods: preintervention, postintervention, and at follow-up. The training entailed four weekly 2-hr trainings for Phase I. Phase II was a service-learning experience at a local elementary school. Participants conducted 16 sessions with children over 8 weeks. Statistics used were the Friedman test (nonparametric ANOVA) and a Wilcoxon signed ranks test. The results showed statistically significant gains in attitudes, knowledge, and skills in play therapy. The authors concluded that service learning in addition to training may make the greatest impact on outcomes. Counselor educators in school-based play therapy training programs were encouraged to consider blending training with this immersion model.

Pereira and Smith-Adcock (2013) conducted a quasi-experimental evaluation of a 12-hr workshop based on coursework in play therapy with school counseling graduate students. Every skill to be utilized was explained, demonstrated, and shown in a video. Group work was then incorporated with practice and role-play opportunities. Limit-setting scripts were provided for role-play activities. Participants were master's level students in three different university programs in school counseling. Students ($N = 40$) were randomly assigned to an experimental or

control group. After the study, control-group participants were offered the exact workshop provided to the experimental group for ethical purposes.

Findings in the quantitative study indicated that a brief 12-hr workshop is sufficient training to improve school counselor students' understanding of child-centered play therapy (Pereira & Smith-Adcock, 2013). The treatment and control groups showed significant differences in knowledge, particularly in the skills of returning responsibility, tracking, reflecting, and limit setting. Participants demonstrated a shift in thinking from the use of directive to humanistic nondirective orientation with children. The PTAKSS-R was the instrument used to examine student training in play therapy. Participants also took the Counseling Self-Estimate Inventory online.

Pereira and Smith-Adcock (2013) used analysis of covariance statistics to compare attitudes, knowledge, skills, and self-estimated counseling ability from pre- to posttesting. The covariates were time in the program, experience with children, effect of presenter, and PTAKSS-R pretest results. No significant differences emerged in covariates. The emphasis of this training was on facilitative skills, so a brief training in play therapy might have promoted counselors' self-efficacy in basic skills development. The knowledge gained might allow for increased counselor competence in play therapy.

Lindo, Chung, et al. (2012) performed a mixed-method study on the impact of training for graduate counseling students on child-centered play therapy. Thirteen students from an introductory play therapy course voluntarily participated. In the quantitative portion, students took a pretest PTAKSS, received the training, and then took a posttest PTAKSS. The qualitative portion included individual interviews about the content and structure of the course. Statistical results indicated a statistically significant, positive correlation in knowledge and skills

acquisition. The qualitative interviews revealed emerging themes that the course (a) was useful, informative, and well organized and (b) provided insight, awareness, self-growth, knowledge, and skills. The researchers concluded that an introductory course, focused on child-centered play therapy, can positively impact graduate counseling students for future work with children.

Smith-Adcock et al. (2012) presented a qualitative study evaluating coursework in a school-based play therapy class. They studied graduate students' reflections on using play therapy with elementary school students. The researchers took a constructivist epistemological stance to elicit deep meaning. A significant human connection was noted with considerable improvement for children. The 21 graduate students provided five to six play sessions with kindergarten and first-grade students. After each session, they reflected in their journal about whom they worked with and where, what play medium they used, what happened, what thoughts and feelings they had, and what they learned about theory and the counseling process.

Each paper was thoroughly reviewed by the instructor and the three doctoral-level teaching assistants using thematic analysis (Smith-Adcock et al., 2012). Categories were derived to provide an in-depth picture. Constant comparative methods were used to give structure to the coding process. Member checking was utilized to provide accuracy and trustworthiness. The results demonstrated four overarching categories: (a) development of play skills, (b) development of advanced play therapy skills, (c) examination of the relationship to children's outcomes, and (d) increased confidence in using play with children. The results suggested that graduate students' experiential learning impacted perceptions of their attitudes, knowledge, and skills using play therapy with children.

Dillman Taylor et al. (2017) examined student play therapy outcomes in an instrumental case study design. They looked at the influence of a constructivist developmental framework on

coursework in counselor education. The framework centered on the idea of using reflective thinking practices. The researchers offered a pre- and posttest measure with open-ended questions; responses were then coded. The researchers used content analysis on responses from 19 student participants. The authors took detailed notes searching for patterns in participants' answers. All 19 showed some improvement in play therapy knowledge and skills.

In their qualitative study, Dillman Taylor et al. (2017) added that play therapy instructors using a constructivist lens can support graduate students transitioning from novice to reflective practitioners, as evidenced in their data showing a 43.2% improvement in knowledge from pre- to posttest. The study provided insights into content and assessment of university-level play therapy courses by using self-reflective practice. Dillman Taylor et al. stated that the results of training demonstrated positive effects primarily in knowledge of play therapy among their sample of graduate students.

Exploring the literature on attitudes, knowledge, and skills in play therapy based on training showed that most studies involved graduate-level counseling students (Lindo, Chung, et al., 2012; Lindo, Meany-Walen, & Sullivan, 2012; Muro et al., 2015) and school counselors (Kagan & Landreth, 2009; Shin & Gonzalez, 2018). Two studies indicated training for practicing counselors (Carnes-Holt & Weatherford, 2013; Lambert et al., 2007). Aside from these listed studies, the literature was sparse concerning professional counselors' attitudes, knowledge, and skills in play therapy based on their training. Most of the research served as program evaluations for graduate program training in play therapy (Dillman Taylor et al., 2017; Kao & Landreth, 1997; Lindo, Chung, et al., 2012), continuing education unit evaluations for play therapy training (Lambert et al., 2007; Ray et al., 2005), or program evaluations of self-produced workshops on play therapy (Carnes-Holt & Weatherford, 2013; Kagan & Landreth, 2009; Pereira & Smith-

Adcock, 2013; Shin & Gonzalez, 2018). Using constructivism was also mentioned in two of the studies as a guide for training (Dillman Taylor et al., 2017; Shin & Gonzalez, 2018). In addition, many of the studies were specific to child-centered play therapy (Kagan & Landreth, 2009; Pereira & Smith-Adcock, 2013; Ray et al., 2015; Wicks et al., 2018).

The current body of knowledge on training in play therapy showed mixed results, as some counselors demonstrated statistically significantly increased knowledge and skills of play therapy through training (Carnes-Holt & Weatherford 2013; Flasch et al., 2017; Kagan & Landreth 2009; Pereira & Smith-Adcock, 2013) but not statistically significant findings regarding improving counselor attitudes (Kagan & Landreth, 2009). Attitude was often not mentioned in results of the studies reviewed. This could be in part because counselors tend to begin with a good attitude and, therefore, their attitude remains the same (Pereira & Smith-Adcock, 2013). Further work is required with consideration given to attitudes, knowledge, and skills of play therapy based on the type and length of training. Research on this topic will add to the body of knowledge in a meaningful way.

Overall, training is key to successful implementation of play therapy (Carnes-Holt & Weatherford, 2013; Lindo, Chung, et al., 2012; Shin & Gonzalez, 2018). Counselors using play therapy within various modalities and settings require a special skill set (Kao & Landreth, 1997). A thorough understanding of attitudes, knowledge, and skills of play therapy is critical for all in the practice (Dillman Taylor et al., 2017; Lindo, Chung, et al., 2012). Future research is, of course, needed to expand upon, validate, and substantiate existing claims (Booth et al., 2003; Muro et al., 2015).

Considering the literature reviewed, counselors evidently are expected to have developed attitudes, knowledge, and skills appropriate for work with young children; these skills often

require competency in an evidence-based method such as play therapy (Lindo, Chung, et al., 2012; Muro et al., 2015; Pereira & Smith-Adcock, 2013; Perryman et al., 2017; Shin & Gonzalez, 2018; Yee et al., 2019). Providing successful counseling relies first on establishing a relationship, building trust, and gentle encouragement toward changing a behavior (Ray et al., 2005). Play therapy has been shown to be an effective method to use with children in counseling because of the strong focus on the child's emotional and developmental needs (Carnes-Holt & Weatherford, 2013). This effectiveness and focus are true across cultures and in a variety of settings (Shen, 2016; Wicks et al., 2018).

The impact of training in play therapy on counselor attitudes, knowledge, and skills is obvious in the literature (Carnes-Holt & Weatherford, 2013; Kagan & Landreth, 2009). Future research is needed regarding types and lengths of training that influence professional counselors and elementary school counselors. All of the studies in the literature review addressed some aspects of the topic of this dissertation study: relationships between professional development and attitudes, knowledge, and skills in play therapy among counselors. Each article, however, was missing key components that this investigation was designed to meaningfully collate after data collection and analysis.

The range of variance between types of play therapy training for counselors working with children is, therefore, an area worth exploring. To fully understand the effectiveness of training, surveys could be conducted with counselors who work with children 3–12 years of age on the counselors' type and degree of play therapy training. The PTAKSS-R could be administered for greater understanding about the varied types of training in play therapy and how those variations relate to self-perceived attitudes, knowledge, and skills of play therapy among the counselors surveyed. The results could prove to be valuable information that makes a difference in the

counseling profession (Creswell & Poth, 2018). Examining differences between the counselors who are APT members and those who are not APT members could provide needed information in regard to membership and attitudes, knowledge, and skills of play therapy.

Future research is needed to better understand (a) how type of training relates to attitudes, knowledge, and skills in play therapy; (b) whether university training predicts higher levels of knowledge; (c) whether knowledge of play therapy predicts skill level for counselors; and (d) how attitudes, knowledge, and skills vary between counselor groups based on APT membership. Counselor groups would be professional counselors and elementary school counselors with APT membership and professional counselors and elementary school counselors without APT membership. The following chapter provides the detailed methods used to accomplish this research project.

Chapter 3

Methods

In a first-of-its-kind study, the purpose and intent was to determine which types of training and whether professional organization membership in play therapy related to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors who work with children 3–12 years of age in the United States. The methods for this systematic investigation were aimed at analyzing data to better understand the relationship between variables (Krathwohl, 2009). These methods included a correlation survey research design, participants, instrument, data collection, and data analysis (Krathwohl & Smith, 2005).

Research Design

A deductive quantitative design was implemented with the use of a survey to explore self-reported attitudes, knowledge, and skills of play therapy among counselors. Correlation survey research provides a numeric description of trends, attitudes, or opinions of a population (Creswell & Creswell, 2018). Survey designs are procedures in which the investigator selects a sample of respondents and collects the data using a questionnaire. The survey used in this research was the PTAKSS-R (Appendix A). The data collected were statistically analyzed by describing responses and testing research questions and hypotheses (see Heiman, 2014). The results were organized and summarized to see patterns that helped draw conclusions (see Krathwohl, 2009). Relating these finding back to the past research on the topic made interpretations more meaningful (see Creswell & Creswell, 2018).

Statistics are used in quantitative research to correctly interpret the data and thus give an objective picture and better understanding (Field et al., 2012). This study utilized a multivariate analysis of variance (MANOVA), correlation, multiple regression analyses, simple linear

regression, and a *t* test for independent samples as statistical analysis (see Heiman, 2014). The data provided more objective results and reduced bias (see Krathwohl, 2009). Various training types such as workshops, institutes, and university coursework were the independent variables (IV); attitudes, knowledge, and skills were the dependent variables (DV). The *t* test assisted in examining the differences in variables between the counselors with APT membership and the counselors without APT membership (see Krathwohl, 2009). Some counselors also had the credential of Registered Play Therapist, Registered Play Therapist-Supervisor, or School Based-Registered Play Therapist, which was taken into consideration in frequencies (see Babbie, 2013).

The numeric description of the data was viewed from a postpositivistic stance (Creswell & Poth, 2018). In postpositivism, conjectures are confirmed by seeing the numbers that discover a reality yet do not confirm an absolute truth (Creswell & Poth, 2018). An objectivist epistemology with a postpositivistic positioning that integrates transformational learning theory (Mezirow, 2004) guided the research study. Transformational learning theory views training as a mechanism for reformulating meaning from a learning experience that results in putting a new skill into practice (Yukawa, 2005). The participants provided feedback about their transformative or nontransformative learning experiences as reflected by their attitudes, knowledge, and skills based on play therapy training (Fazio-Griffith & Ballard, 2016).

Participants

A sample consists of participants taken from a population who accurately represent the variables of interest (Krathwohl, 2009). The participants in this study were professional counselors and elementary school counselors across the United States who counsel children 3–12 years of age. With the current School Based-Play Therapist credential that focuses on school counselors and play therapy, surveying school counselors in addition to professional counselors

was appropriate at this time (Hudspeth, 2016). Criteria for participating in the survey included (a) having a U.S. license in counseling or a certification in elementary school counseling, (b) having counseled or planning to counsel children 3–12 years of age, and (c) having the technology available to complete the survey (Appendix A).

The target population for this sample was all U.S. counselors who meet the criteria (Krathwohl, 2009). A power analysis was run to have a clear understanding of how many participants were needed in the study (Creswell & Creswell, 2018). The sample size was estimated to be 266–378 participants. This range was determined by using the Raosoft (2020) sample size calculator as the power analysis. The researcher input the margin of error at 5%, confidence level at 90%, the population set at 20,000, and the response distribution at 50% for lower range of the sample size. The researcher then input the margin of error at 5%, confidence level at 95%, the population set at 20,000, and the response distribution at 50% for the higher range of the sample size. By changing the confidence level from 90% in the lower range of the sample to 95% in the higher range of the sample, an estimated range was determined. Obtaining this estimated sample size helped to give the study statistical power (Creswell & Creswell, 2018).

After Institutional Review Board (IRB) approval was received (Appendix B), recruitment for participants from the APT ensued (Appendix C). An application was sent to the APT that included a letter of approval from the IRB and other supporting documents. Once approval from the APT was received, I sent a survey link to email addresses on the member roster (APT, 2020d). Professional counselors and elementary school counselors were recruited from the APT roster by email to participate in the study in a voluntary response, nonrandom selection.

Participants answered the qualifying questions that allowed them to participate in the study and survey (see Terrell, 2016).

Recruitment for counselors from applicable counselor groups on social media began immediately after IRB and Facebook group administrator approval (see Krathwohl, 2009) (Appendix C). These included elementary school counselor groups/school counselor groups and professional counselor/mental health professionals groups on Facebook. The sample was a voluntary response, nonrandom sample from the Facebook groups (Creswell & Creswell, 2018). The groups included the elementary school counselor, licensed professional counselors, therapists in private practice, teletherapy activities for kids, mental health professionals, school counselors connect, counselor/therapist networking/consultation group, and school counseling essentials groups (Facebook Counselor Groups, 2020).

The demographics gathered (see Krathwohl, 2009) were the amount and type of play therapy training, credentials held, whether the counselors graduated from a CACREP-accredited institution, whether the counselors were APT members, number of years counseling, U.S. state where the respondents practice or work, gender, and age. Training in play therapy was described in three parts: university course credit hours that included play therapy, institute or conference training hours in play therapy (multiday,) and play therapy workshop training hours (1 day or shorter). The credential section in the demographics included the following: school counselor certification, professional counselor, Registered Play Therapist, Registered Play Therapist-Supervisor, School Based-Registered Play Therapist, master's in counseling, doctoral student in counseling, and doctorate degree in counseling. Whether the participant graduated from a CACREP-accredited institution was answered with yes or no. Whether the participant was an APT member was answered with yes or no. Number of years of counseling was divided into four

choices: 0–5, 6–12, 13–20, and 20+ years. State or region in the country was a fill-in-the-blank statement. Gender included male, female, and undifferentiated. Age was presented by three ranges: 21–35, 36–50, and 51+ years. See Appendix A for the demographic information entered in the survey-management software program (Qualtrics, 2020).

A survey question asked whether the respondent was an APT member. The APT (2020g) has several membership types: professional membership, affiliate membership, e-student membership, international membership, and international affiliate. An affiliate is a full-time graduate student or a non-mental-health professional. The e-student membership includes full-time graduate or doctoral students in a mental health field (APT, 2020g). This study looked at those counselors who were in the professional membership category and doctoral students who may be licensed in the e-student membership category. This was based on criteria outlined earlier and on definitions of APT membership (APT, 2020g).

A link to the Likert-scale survey was included in the invitation for participation (see Appendix D) along with an informed consent prior to taking the survey (Krathwohl, 2009). This study was low risk for participants as they were not asked anything that is highly sensitive or personal (Creswell & Creswell, 2018). Participants voluntarily took an anonymous survey that was only 10–15 min in length. The cost to participants was their time (see Creswell & Creswell, 2018).

Instrument

The instrument used to collect data was the PTAKSS-R (Kao, 2009). The PTAKSS-R is a 63-item Likert-scale survey (ranging from 1–5) designed to measure outcomes of play therapy training. Each factor contains pertinent questions, 23 from the attitude factor, 18 from the knowledge factor, and 22 from the skills factor. Permission to utilize the PTAKSS-R for this

research was initially granted by the Department of Counseling of the University of North Texas (N. A. Lindo, personal communication, November 6, 2017). See Appendix D for email permission. In its original form, the PTAKSS was developed by Kao and Landreth (1997) with 88 items; the survey was later revised by Kao and Chang (2007) to 63 items. Permission was granted May 6, 2020, by the primary author of the PTAKSS-R, Dr. Shu Chen Kao, for use of the instrument in this study (see Appendix D). The full text of the instrument is included in Appendix A.

The original PTAKSS was designed to measure three constructs: attitudes, knowledge, and skills after receiving play therapy coursework or training (Carnes-Holt & Weatherford, 2013). It is a measure of the individual's perception of those three constructs (G. Landreth, personal communication, March 24, 2020; Appendix D). Two major sources in child-centered play therapy were used in developing the PTAKSS: *Play Therapy* (Axline, 1947) and *The Art of the Relationship* (Landreth, 1991). Researchers have used this survey in various studies (Crane & Brown, 2003; Kao & Landreth, 1997; Lindo, Chung, et al., 2012; Lindo et al., 2016; Meany-Walen et al., 2015; Muro et al., 2015). Additionally, the PTAKSS has been administered in diverse settings such as universities with graduate students (Homeyer & Rae, 1998; Kao & Landreth, 1997) and undergraduate human services majors (Crane & Brown, 2003), with school counselors (Kagan & Landreth, 2009), and with mental health counselors (Meany-Walen et al., 2015).

The PTAKSS-R, though newer, has been used in numerous play therapy training studies as well (Bratton et al., 1993; Homeyer & Rae, 1998; Lindo, Chung, et al., 2012; Muro et al., 2015; Pereira & Smith-Adcock, 2013; Perryman et al., 2017; Thanasiu et al., 2018). The PTAKSS-R is a self-report measure that examines growth in attitudes, knowledge, and skills as a

result of play therapy training (Thanasiu et al., 2018). The areas of self-perceived changes include beliefs about children, basic knowledge of play therapy, and the ability to transfer play therapy knowledge into application of those skills (Kao & Landreth, 1997). Perceptions of the trainees regarding outcomes of instruction is the focus of the comprehensive measure (Kao & Chang, 2007).

Psychometrics from the PTAKSS-R showed high internal consistency reliability (a = .95) and a good split-half reliability (*r* = .76; Lindo et al., 2016; Muro et al., 2015; Perryman et al., 2017). The Cronbach's alpha was also calculated for the subscales, which yielded a score of .86 for the attitude subscale, .91 for the knowledge subscale, and .98 for the skills subscale (Muro et al., 2015; Thanasiu et al., 2018). These reliability coefficients indicate a high degree of reliability of obtained results for this instrument. Kao and Chang (2007) conducted a factor analysis on the PTAKSS-R and found that 47.6% of variance of the scale scores was accounted for by the three factors. These validity results indicate that the PTAKSS-R is a sound measurement tool. Validity is the degree to which evidence and theory support interpretation of test results (DeVellis, 2017).

The items in the instrument are direct and clear (DeVellis, 2017) in regard to the three subsets: counselor attitude, knowledge, and skills of play therapy. Reponses to the items for the attitude subset are on a 5-point ordinal scale with *strongly disagree* and *strongly agree* as bookend responses (Krathwohl, 2009). Responses to the items for the knowledge and skills subsets are on a 5-point ordinal scale with *none* and *very good* as anchored responses on each end (Creswell & Creswell, 2018). Items in the attitude subset (Kao, 2009) include "1. I am willing to and like to work with children," "11. Children experience the depth of inner emotions that adults are capable of experiencing," and "20. Play is good for physical and mental health." Items on the knowledge subset (Kao, 2009) include "24. How would you rate your knowledge of

play therapy as an approach for counseling with children?" and "29. How would you rate your understanding of symbolic play in play therapy?" Items on the skills subset (Kao, 2009) include "42. How would you rate your ability to effectively assess the mental health needs of a child?" and "56. How would you rate your ability to track a child's behavior in play therapy?" See Appendix A of this document to view all items in the PTAKSS-R survey.

Data Collection and Analysis

Qualtrics was used for survey data collection (Creswell & Creswell, 2018). Qualtrics (2020) is an online management system for survey entry and storage. Respondents used a link to an anonymous online survey containing the PTAKSS-R. I posted a link to each of the counselor groups on Facebook and then to individual emails of members from the APT roster in a non-random sampling (APT, 2020e; Creswell & Creswell, 2018). All counselors received the same link. The demographics and survey items were exactly the same (Field et al., 2012). The counselors completed and submitted their feedback regarding attitudes, knowledge, and skills in play therapy. To achieve a higher rate of return, a motivating message stressing the importance of replies was issued with the link (Creswell & Creswell, 2018). This included statements such as, "Your answers will provide needed feedback" and "Your input is needed for this important study" (Krathwohl, 2009).

Since the data were in a 5-point Likert-scale format, the data were downloaded from Qualtrics into SPSS format where descriptive and inferential statistics were then computed (Field et al., 2012). Descriptive statistics included demographic question responses, means, standard deviations, and frequencies (Heiman, 2014). Demographic information was collected from the survey (Krathwohl, 2009). Frequencies were used to glean a better understanding of the participants' background and training (Babbie, 2013). The three areas of training were on the

same clock-hour metric, which meant that the university training needed to be transformed from semester hours to clock hours (Field et al., 2012). Inferential statistics were run to see if relationships were statistically significant (Heiman, 2014). The information gathered gave a better understanding of the relationship between participants' play therapy attitudes, knowledge, and skills and types of training acquired in the field.

Inferential statistics included a MANOVA, correlation, regression, and a *t* test for independent samples (Krathwohl, 2009). The means of the scaled scores were calculated and compared (Heiman, 2014). A *t* test for independent samples was conducted between the counselor group with APT membership and the counselor group without APT membership group (Heiman, 2014). Statistics aided in contributing value free numeric information to the research project (Roberts & Hyatt, 2018). I looked for statistical significance in each of the measures (Field et al., 2012).

Research Question 1

What types of training in play therapy relate to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors? To assess the relationship between play therapy attitudes, knowledge, and skills and various levels of training, a MANOVA was run on the data (Heiman, 2014). MANOVA is a parametric procedure that extends the basic ANOVA to situations where more than one outcome variable is measured (Field et al., 2012). This analysis provided the strong, robust results needed to answer this question, since it incorporates several outcome measures. The MANOVA also has greater power to detect an effect or magnitude of each comparison.

Research Question 2

Does the number of hours in play therapy training type have a relationship with the counselors' attitudes, knowledge, and skills in play therapy? A multiple regression analysis gave information about whether hours of training predicted higher levels of attitudes, knowledge, and skills (see Heiman, 2014; Krathwohl, 2009). Regression is the prediction of one variable to the other variable (Field et al., 2012). Since more than one area was in question about prediction, a multiple regression analysis was used (see Field et al., 2012; Heiman, 2014). The regression equation allowed for a regression line that determined if an unknown Y score was based on the X scores (Heiman, 2014).

A simple linear regression provided information about whether knowledge predicted skill level in play therapy. First, a Pearson product-moment correlation test was used to see if there was a correlation between these two variables. In correlation, I looked for a positive correlation indicating that the variables vary directly or a negative correlation showing that the variables vary inversely. With 0 indicating no relation and ±1.00 being a perfect correlation, the data uncovered a relationship (Heiman, 2014). Once correlation was established, a simple linear regression analysis could be conducted.

Research Question 3

What is the relative influence of membership in the APT on attitudes, knowledge, and skills of play therapy between the two groups of counselors (those with and those without APT membership)? A *t* test for independent samples was utilized to better understand the between-groups comparison and the variance assumed (Heiman, 2014). The *t* test was utilized to measure variations between the counselor group with APT membership and the counselor group without APT membership (Krathwohl, 2009). The *t* test for independent samples is the procedure used

for significance testing of means from two independent samples (Heiman, 2014). The population variance between groups was identified by using a Levene's test for equality of variances (Field et al., 2012). This variance was in relation to membership in the APT on the dependent variables of attitudes, knowledge, and skills (Heiman, 2014).

Homogeneity of variance by using a Levene's test was employed to see if the data described populations represented by the samples that have the same variance (Heiman, 2014). The alpha level was set at .05 to determine a *p* value or probability value. The results were examined to determine statistical significance (Field et al., 2012; Heiman, 2014). I also identified the *F* ratio and degrees of freedom (Field et al., 2012). The *t* test compared the sample means of the two groups (Krathwohl, 2009). This helped to determine any statistically significant differences between the variables (Heiman, 2014).

Hypotheses in the Study

Four hypotheses related to the research questions were formulated for this study. Hypotheses are predictions that a researcher makes about the expected outcomes (Field et al., 2012). These hypotheses are then tested by statistical procedures to draw an inference about a specific sample (Heiman, 2014). A null hypothesis states that there is no relationship between variables or groups. An alternative hypothesis states that there is a relationship between variables or groups, and therefore the null is rejected (Krathwohl, 2009). The hypotheses considered in this study were the following:

H1. Counselors with university-level training will have higher levels of attitude, knowledge, and skills at a statistically significant level.

H2. Increased number of hours in university training will predict higher attitudes, knowledge, and skills at a statistically significant level.

H3. Knowledge in play therapy will predict skill level of the counselor at a statistically significant level.

H4. Counselors with APT membership will have statistically significantly higher attitudes, knowledge, and skills than counselors without APT membership.

Chapter 4

Results

This study was designed to compare relationships between professional development and attitudes, knowledge, and skills in play therapy among professional counselors who are licensed and elementary school counselors in the United States who counsel children 3–12 years of age. Professional development was defined as different types of training and professional organization membership in the APT. The study looked at whether the types of training in play therapy predicted attitudes, knowledge, and skills and whether knowledge predicted skills. The study further sought to determine whether membership in the APT made a significant difference in attitudes, knowledge, and skills for counselors. The PTAKSS-R (Kao, 2009) was used to measure self-reported attitudes, knowledge, and skills in play therapy of counselors. The respondents who participated in the study completed an online anonymous survey that included a demographic questionnaire. Descriptive data from this cross-sectional sample population and results from the inferential data analyses are reported in this chapter.

Descriptive Data

I first examined descriptive statistics to better analyze demographics; education level; the mean of scaled scores in attitudes, knowledge, and skills; the means of training hours by type; and counselors with no training in each category. The participants included 333 respondents from various counselor groups who completed the survey online via a Qualtrics link. A total of 498 respondents began the survey, but 165 did not meet the qualifying criteria or did not complete the survey, which left a sample of 333 to be used in the study. The survey availability ran from July 23 to August 14, 2020. The link was sent to a variety of professionals from the mental health field through Facebook counseling/mental health groups and the APT membership

email roster. Both sources required approval prior to posting or receiving and sending emails. A sample size of 266–378 was needed to power this study, so the sample of 333 exceeded the estimate.

The demographic characteristics revealed that ages and number of years in counseling were fairly evenly distributed in this sample (see Table 1). The percentage of female at 95% was significantly higher than that of male participants.

Table 1

Demographic Characteristics of Participants

Characteristics	*n*	%
Gender		
Female	315	94.6
Male	18	5.4
Age		
21–35	76	22.8
36–50	135	40.5
51+	122	36.6
Number of years in counseling		
0–5	72	21.6
6–12	109	32.7
3–20	85	25.5
51+	67	20.1

Note. $N = 333$.

APT members comprised 85% of the participants (see Table 2). Additionally, 70% of all surveyed held a Registered Play Therapist, a School Based-Registered Play Therapist, or a Registered Play Therapist-Supervisor credential. Further, 265 had a master's degree in counseling. The descriptive statistics indicated this sample of counselors was highly qualified, highly educated, and highly credentialed in the area of play therapy.

Table 2

Descriptive Statistics for Counselors

Certification or membership	*n*	%
Certification		
Elementary school counselor certification	27	8.1
Licensed counselor & elementary school counselor combined	34	10.2
Licensed counselor	272	81.6
Master's in counseling	265	79.6
Doctorate in counseling	16	10.2
Doctoral student in counseling	34	4.8
Registered Play Therapist	137	41.1
School Based-Registered Play Therapist	5	1.5
Registered Play Therapist-Supervisor	91	27.3
Association for Play Therapy (APT)		
APT members	283	85.0
Non-APT member	50	15.0
Council for Accreditation of Counseling and Related Educational Programs (CACREP)		
CACREP member	237	71.2
Non-CACREP member	96	28.8

Note. $N = 333$.

The counselors who participated were also from various regions across the United States. Counselors from all 50 states were represented in this study. Since all states and regions of the United States were represented, the various licensures were represented as well. Table 3 includes the number of counselors in the sample holding various licenses. Elementary school counselors, though not licensed, were also well represented in some form at 61 (in frequencies) and 71 in education demographics (those who held elementary school counselor certification).

Table 3

Number and Percentage of Participants by Counselor Type

Counselor type	*n*	*%*
Elementary school counselor	27	8.1
Licensed clinical mental health counselor (LCMHC)	8	2.4
LCMHC-supervisor	1	0.3
Licensed clinical professional counselor (LCPC)	15	4.5
LCPC & elementary school counselor	2	0.6
LCPC & licensed mental health counselor (LMHC)	1	0.3
Licensed independent mental health counselor	1	0.6
LMHC	36	10.8
LMHC & elementary school counselor	3	0.9
LMHC & licensed professional counselor (LPC)	1	0.3
LMHC-supervisor	1	0.3
LPC	153	45.9
LPC & elementary school counselor	24	7.2
LPC, LCMHC, & elementary school counselor	1	0.3
LPC & LCPC	1	0.3
LPC & licensed professional clinical counselor (LPCC)	2	0.6
LPC-mental health service provider	2	0.6
LPC-supervisor	22	6.6
LPC-supervisor & elementary school counselor	2	0.6
LPCC	18	5.4
LPCC & elementary school counselor	1	0.3
LPCC-supervisor	8	2.4
Licensed professional counselor of mental health	1	0.3

Note. $N = 333$.

The Likert-style responses from the instrument used in the study, the PTAKSS-R (Kao, 2009), ranged from 1–5, with 1 being lowest level of attitudes, knowledge, and skills, and 5 being the highest score. The dependent variables measured by this tool included attitudes, knowledge, and skills in play therapy. The independent variables examined in the study were

university coursework hours, institute/professional conference, and workshop training hours in play therapy. The means and standard deviations for these are shown in Table 4.

Table 4

Dependent and Independent Variable Descriptive Statistics

Variables	*M*	*SD*
Dependent variables		
Attitudes	4.44	0.325
Knowledge	4.13	0.569
Skills	4.31	0.538
Independent variables		
University hours	96.04	163.97
Institute/professional conference	69.03	95.88
Workshop training hours in play therapy	65.82	86.99

Note. Scores for dependent variables could range from 1–5.

The means for dependent variables indicated that this sample of counselors had high levels of self-reported attitudes, knowledge, and skills. To measure the training hours on the same standard, university coursework hours were transformed to clock hours. I multiplied the credit hours reported by 15, which is the formula utilized by APT (2020b) for determining university course credits that count toward the Registered Play Therapist credentials. When comparing the means for professional development from this study with Lambert et al. (2007), the hours reported in this study were on the moderate end of the scale for training. In Lambert et al., ACA members held an average of 17.6 hr, and APT members held 121 hr of continuing education units in play therapy.

When examining the results from the CACREP-accredited programs in comparison with the non-CACREP accredited programs, the training hours mean and the attitudes, knowledge, and skills means were slightly higher for counselors from CACREP programs, though not by

much of a margin, with the exception of university coursework in play therapy. Counselors from CACREP programs averaged 8 credit hr, whereas counselors from nonaccredited programs averaged 3 credit hr in play therapy.

To discern percentages of counselors who had no training hours in each of the training types, the frequency data were disaggregated for number of training hours that resulted in 0 for each category (see Table 5). These data indicated elementary school counselors had the least amount of play therapy training overall, in comparison with the other two groups.

Table 5

Percentage of Counselors by Counselor Type With No Training in Play Therapy

Counselor type	No university hours	No institute/conference	No workshops
Elementary school counselor	44	56	30
Licensed & elementary school counselor	24	12	15
Licensed counselor	42	10	7

Reviewing frequencies of the different age groups for professional counselors and elementary school counselors combined ($N = 333$) in relation to university training in play therapy revealed no differences. After disaggregating the data based on age, each category revealed that approximately 40% had no university coursework in play therapy. The 21–35, 36–50, and 51+ age groupings separately displayed equal findings; therefore, there was no indication that more play therapy training at the university level increased through the years.

Analysis of Research Questions

The research questions were then analyzed based on applicable corresponding inferential statistical analyses (Heiman, 2014). Research Question 1 was a comparison of relationships;

therefore, a MANOVA was conducted. A multiple regression analysis and simple regression analysis were used for Research Question 2, as some of the variables might predict other variables. A Pearson product-moment correlation was first used to better understand the relationship between knowledge and skills. Once a correlation was established, the simple linear regression was conducted. As Research Question 3 compared two different groups, a *t* test was run to make those determinations. The level of significance of .05 was used for each statistical analysis. Effect size was also explained to better understand the magnitude of each comparison in the study.

Research Question 1

What types of training in play therapy relate to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors? A MANOVA was conducted to determine if there was a significant correlation between types of training and attitudes, knowledge, and skills in play therapy. A post hoc test was not needed because there were fewer than two groups once assumptions were met for the MANOVA (see Field et al., 2012). The results revealed that university coursework correlated with attitudes, knowledge, and skills at a statistically significant level. Institute/professional conference and workshop training correlated with knowledge and skills but not attitudes.

Hypothesis 1 stated that counselors with university-level training would have higher levels of attitude, knowledge, and skills at a statistically significant level. The results showed a statistically significant relationship between university hours and all three of the dependent variables (Table 6). I was able to reject the null hypothesis. These results were expressed as attitudes, $F(1, 333) = 10.216$, $p < .01$; knowledge, $F(1, 333) = 15.935$, $p < .001$; and skills, $F(1,$

333) = 10.787, $p < .01$. The counselors surveyed who took university coursework in play therapy reported high scores in each subset. These data supported Hypothesis 1.

Table 6

Means, Standard Deviation, and Multivariate Analysis of Variance Statistics for Study Variables and University Training

Variable	*M*	*SD*	Effect	*F* ratio	*df*
Attitudes	4.44	0.325	.027	10.22**	1
Knowledge	4.13	0.568	.043	15.94***	1
Skills	4.31	0.538	.029	10.79**	1

**$p < .01$. ***$p < .001$.

A positive, statistically significant relationship was found between knowledge and institute/professional conference training in play therapy (see Table 7). A statistically significant, positive relationship also was found between skills and institute/professional conference training in play therapy. Attitudes, however, was not found to be related. The result outcomes evinced high knowledge and skills of play therapy as a result of institute/professional conference training.

Table 7

Means, Standard Deviation, and Multivariate Analysis of Variance Statistics for Study Variables and Institute/Conference Training

Variable	*M*	*SD*	Effect	*F* ratio	*df*
Attitudes	4.44	0.325	-.002	0.452***	1
Knowledge	4.13	0.569	.127	49.26	1
Skills	4.31	0.538	.099	37.51***	1

***$p < .001$.

A statistically significant, positive relationship was exhibited between knowledge and workshop training in play therapy (see Table 8). Skills were also related at a statistically significant level. Again, the attitudes subset was not found to be related. These data suggested

that the amount of knowledge and skills in play therapy was higher as a result of workshop training in play therapy.

Table 8

Means, Standard Deviation, and Multivariate Analysis of Variance Statistics for Study Variables and Workshop Training

Variable	*M*	*SD*	Effect	*F* ratio	*df*
Attitudes	4.44	.325	.000	0.883	1
Knowledge	4.13	.569	.107	40.73***	1
Skills	4.31	.538	.079	29.55***	1

*** $p < .001$.

The effect sizes were considered weak overall in this MANOVA study. Krathwohl (2009) stated, "Effects of 1 are considered strong in the behavioral sciences; effect size of .3 or below, weak" (p. 521). Though there is argument on this topic among statisticians, it is presumed that with a larger sample size, such as in this study, the *p* value is what holds true and robust (Wan, 2020). Thus, a relationship did exist between training types and attitudes, knowledge, and skills at a statistically significant level. The hypothesis for Research Question 1 was supported as the data uncovered relationships.

Research Question 2

Does the number of hours in play therapy training type have a relationship with the counselors' attitudes, knowledge, and skills in play therapy? A multiple regression statistical analysis was run to investigate this research question. Heiman (2014) defined "multiple correlation and multiple regression as procedures for describing the relationship when multiple predictor (X) variables are simultaneously used to predict scores on one criterion (Y) variable" (p. 181). The three predictor variables were university coursework in play therapy, institute/professional conference training in play therapy, and play therapy workshop training.

These predictor variables were correlated separately with each of the dependent variables or attitudes, knowledge, and skills in play therapy. In addition, a simple regression analysis was conducted to determine if knowledge in play therapy predicted skill.

Upon running a multiple regression for each of the dependent variables, I checked the assumptions of the multiple regression model. Assumptions of the multiple regression model included existence of a relationship between independent and dependent variables, linearity, homoscedasticity, and multicollinearity (Field et al., 2012). To begin this process, I first recognized a correlation between training hours and all three of the dependent variables. The data therefore met the criteria necessary for a multiple regression; a relationship exists between variables. Next, the means were standardized to z scores for the independent variables to identify possible outliers. A total of 20 outliers surfaced in the multiple regression analysis, including 10 from university coursework, 5 from institute/professional conference training, and 5 from workshop training. The criterion for elimination was a z score higher than 3.20 in each category. Once these were removed, I ran a second multiple regression using the new independent variable predictors data set.

Hypothesis 2 for this research question stated that increased number of hours in university training would predict higher attitudes, knowledge, and skills at a statistically significant level. In the regression analysis, the mean for university hours was 78.45 hr (*SD* = 113.37), the mean for institute or conference training hours was 57.80 hr (*SD* = 56.46), and the mean for play therapy workshop hours was 55.23 hr (*SD* = 52.26). The means for attitudes scale score (*M* = 4.44, *SD* = 0.33,) knowledge scale score (*M* = 4.10, *SD* = 0.57,) and skills scale score (*M* = 4.29, *SD* = 0.54) were displayed. A multiple regression analysis was used to investigate

whether each dependent variable could be predicted by a linear combination of multiple independent variables.

Upon running the first multiple regression analysis, the three predictor variables and the dependent variable of attitudes mean were entered. The second analysis included the three predictor variables and the dependent variable of knowledge mean. The third contained the three predictor variables and the dependent variable of skills mean. A stepwise method was used under Durbin-Watson to obtain a model summary for each dependent variable. An ANOVA was run as part of the analysis along with the coefficients and collinearity diagnostics. Collinearity was tested with values for tolerance and the variance inflation factors (see Table 9).

Table 9

Tolerance and Variance Inflation Factors for Attitudes and the Independent Variable Predictors

Independent variable	Tolerance	Variance inflation factor
University coursework,	.975	1.025
Institute/professional conference, &	.845	1.184
Workshop training in play therapy	.834	1.199

The values for tolerance and variance inflation factors showed that the data stayed within the limits of collinearity for all of the independent variables. The attitude variable revealed that all three independent variables were a constant. For the dependent variable attitudes mean, the combination of university coursework, institute/professional conference, and workshop training in play therapy proved to be the constant predictor, $F(310) = 1.17$, $p < .001$ (Table 10). There was indication of statistical significance, $p = .000$, when all three independent variables were combined. The sample multiple regression coefficient (R) was .106, indicating that approximately 1.12% of the variance in this sample can be accounted for by the attitudes subcomponent of the PTAKSS-R (Kao, 2009).

There was not one independent variable that surfaced as a single constant, only the combination of all three training types. Null Hypothesis 2 for this research question, stating that increased number of hours in university training would not predict higher attitudes, knowledge, and skills at a statistically significant level, could not be rejected.

Table 10

Multiple Regression Analysis of Training Type Predictors of Attitudes

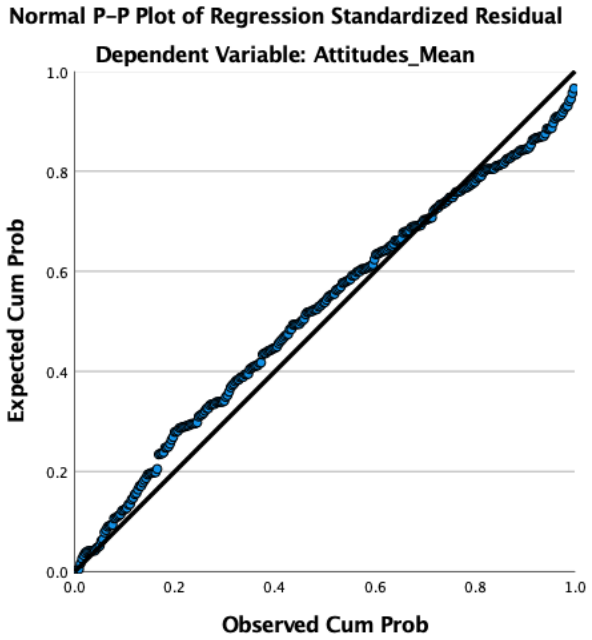
Effect	Estimate	SE	95% confidence interval	*p*
University, institute/conference, & workshop training combined	4.40	.033	[4.33, 4.46]	.000***

***$p < .001$ (two-tailed).

The histogram of standardized residuals (Figure 7) and the normal P-P plot (Figure 1) indicated by their shapes that all requirements for the normally distributed residuals were met. The scatterplot of regression standardized residuals (Figure 8) showed a fairly linear set of points without outliers. The Durbin-Watson statistic was computed to evaluate independence of errors. The data met the assumption of independent errors (Durbin-Watson value = 2.015). All assumptions of statistical testing were met, indicating that results of this multiple regression were reliable.

Figure 1

Normal P-Plot of Regression Standardized Residual of Attitudes (Dependent Variable) and Training Types (Independent Variable)



Collinearity was then tested with values for tolerance and the variance inflation factors for the knowledge variable. The values for tolerance and variance inflation factors showed that the data stayed within the limits of collinearity for all of the independent variables (see Table 11).

Table 11

Tolerance and Variance Inflation Factors for Knowledge and the Independent Variable Predictors

Independent variables	Tolerance	Variance inflation factor
Workshop training in play therapy	1.000	1.000
Workshop and	.853	1.172
Institute/professional conference	.853	1.172
Workshop,	.834	1.199
Institute, and	.845	1.184
University hours	.975	1.025

The constant predictors for the dependent variable, knowledge mean, were play therapy workshop training hours, $F(312) = 41.41$, $p < .01$; and then a combination of workshop and institute/professional conference training hours in play therapy, $F(311) = 31.37$, $p < .01$; and finally a combination of all three independent variables, $F(310) = 26.74$, $p < .01$ (Table 11). The sample multiple regression coefficient was $R = .343$ for workshop training hours and $R = .410$ for the combination of workshop and institute/professional conference hours. Finally, the combination of all three independent variables yielded $R = .454$. These results indicated that approximately 12%, 17%, and 21% of the variance in this sample, respectively, can be accounted for by the knowledge subcomponent of the PTAKSS-R. The most notable characteristic for this predictor was that it was at the statistically significant level based on the ANOVA report at $p < .001$ in all of the constants (see Table 12). Workshop training was the highest predictor of knowledge in play therapy.

Table 12

Multiple Regression Analysis of Training Type Predictors of Knowledge

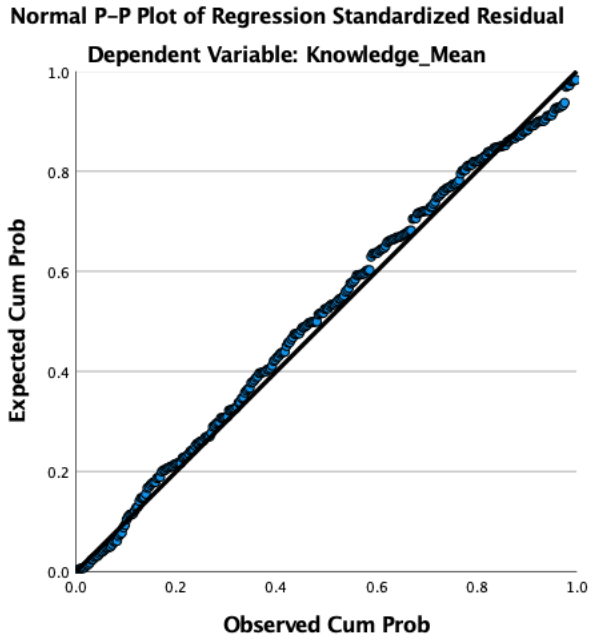
Effect	Estimate	SE	95% confidence interval	*p*
Workshop	3.90	.044	[3.81, 3.98]	.000***
Workshop & institute/conference	3.81	.047	[3.72, 3.90]	.000***
Workshop, institute/conference, & university training combined	3.73	.051	[3.63, 3.83]	.000***

***$p < .001$ (two-tailed).

Both the histogram of standardized residuals (Figure 9) and the normal P-P plot (Figure 2) showed by their shapes that all requirements for the normally distributed residuals were met. The scatterplot of regression standardized residuals (Figure 10) displayed a fairly evenly distributed set of points, indicating that the data met the assumptions of homogeneity of variance and linearity. The Durbin-Watson statistic was computed to evaluate independence of errors. The data met the assumption of independent errors (Durbin-Watson value = 1.72.) All assumptions of statistical testing were met, indicating results of this multiple regression were reliable.

Figure 2

Normal P-P Plot of Regression Standardized Residual of Knowledge (Dependent Variable) and Training Types (Independent Variable)



Collinearity was tested with values for tolerance and the variance inflation factor for the skills variable (see Table 13). The values for tolerance and variance inflation factor showed that the data stayed within the limits of collinearity for all of the independent variables.

Table 13

Tolerance and Variance Inflation Factors for Skills and the Independent Variable Predictors

Independent variable	Tolerance	Variance inflation factor
Institute/professional conference	1.00	1.000
Institute/professional conference &	.853	1.172
Workshop training in play therapy	.853	1.172
Institute/professional conference,	.845	1.184
Workshop training in play therapy, &	.834	1.199
University coursework	.975	1.025

The constant predictors for the skills mean were institute/professional conference training hours, $F(312) = 29.39$, $p < .01$; then a combination of institute/professional conference workshop training hours in play therapy, $F(311) = 21.18$, $p < .01$; and finally, a combination of all three training types, $F(310) = 17.49$, $p < .01$ (Table 6). The sample multiple regression coefficient was $R = .294$ for institute/professional conference training hours, $R = .347$ for the combination of institute/professional conference and workshop hours, and $R = .381$ for all three training types, indicating that approximately 8.6%, 12%, and 14.5% of the variance in this sample, respectively, can be accounted for by the skills subcomponent of the PTAKSS-R (Kao, 2009). The most notable characteristic for this predictor was that it was at the statistically significant level based on the ANOVA report at $p = .000$ in all of the constants (see Table 14). Institute/professional conference training resulted as the highest predictor of skills in play therapy.

Table 14

Multiple Regression Analysis of Training Type Predictors of Skills

Effect	Estimate	SE	95% confidence interval	*p*
Institute/conference	4.13	.042	[4.05, 4.21]	.000***
Institute/conference & workshop	4.06	.046	[3.97, 4.15]	.000***
Institute/conference, workshop, & university training combined	4.00	.050	[3.90, 4.09]	.000***

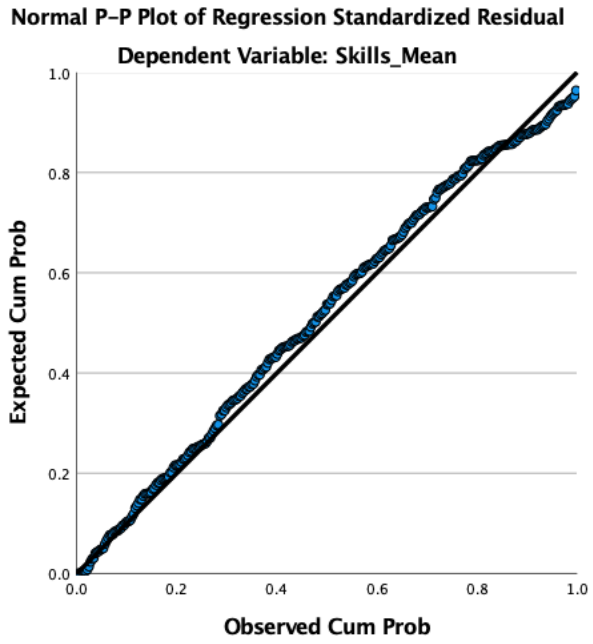
***$p < .001$ (two-tailed).

Both the histogram of standardized residuals (Figure 11) and the normal P-P plot (Figure 3) indicated by their shapes that all requirements for the normally distributed residuals were met. Additionally, the scatterplot of regression standardized residuals (Figure 12) showed a fairly evenly distributed set of points, indicating that the data met the assumptions of homogeneity of variance and linearity. The Durbin-Watson statistic was computed to evaluate independence of

errors. The data met the assumption of independent errors (Durbin-Watson value = 1.70). All assumptions of statistical testing were met, indicating results of this multiple regression were reliable. The model summary outlined an overall fit of the model.

Figure 3

Normal P-P Plot of Regression Standardized Residual of Skills (Dependent Variable) and Training Types (Independent Variable)



This study found that all three predictor variables made a statistically significant contribution to the attitudes, knowledge, and skills response variables. The results demonstrated that although all training types held some predictive value, play therapy workshop training most predicted high levels of knowledge, institute/professional conference training most predicted skills, and a combination of all three training types was a significant predictor of the attitudes subset. Although the data uncovered predictor variables for Research Question 1, the hypothesis that university coursework would be the highest single predictor was not supported.

Hypothesis 3 was also tested with regression analysis. This hypothesis stated that knowledge in play therapy would predict skill level of the counselor at a statistically significant level. A Pearson product-moment correlation was run first to determine if there was a relationship between knowledge and skills. When looking at correlation, a number between 0 and ±1.00 indicated the strength of the relationship between two variables (Krathwohl, 2009). There was a very high correlation between the subsets knowledge and skills (r = .873) that was statistically significant, $r(331) = .873$, $p < .01$ with an effect size of $r^2 = .76$ (Table 15). The effect size in this correlation is also considered very high. These findings were consistent with correlations in the pilot study conducted as part of this project (Anderson, 2019). The hypothesis that knowledge in play therapy would predict skill level of the counselor at a statistically significant level could now be tested in a simple linear regression analysis.

Table 15

Correlation Between Knowledge and Skills Mean Scores

Variable	*N*	*M*	*SD*	*R*
Knowledge	333	4.13	0.569	.873**
Skills	333	4.31	0.538	.873**

**$p < .01$ (two-tailed).

A simple linear regression was conducted to test if knowledge predicted skills in play therapy (Table 16). The constant predictor for the skills mean was knowledge, $F(312) = 948.471$, $p < .001$. The sample multiple regression coefficient (R) = .868 for regression indicated an effect size of $r^2 = .75$; therefore, approximately 75% of the variance in this sample can be accounted for by the knowledge subcomponent of the PTAKSS-R (Kao, 2009). The results demonstrated that knowledge does predict skill level in play therapy; therefore, Hypothesis 3 was supported.

Table 16

Simple Linear Regression Analysis of Knowledge as a Predictor of Skills in Play Therapy

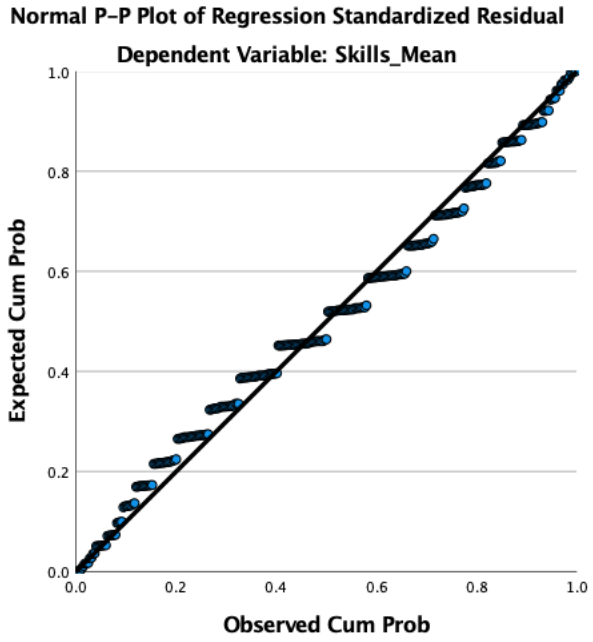
Effect	Estimate	SE	95% confidence interval	*p*
Knowledge	0.823	.027	[0.770, 0.876]	.000***

***$p < .001$ (two-tailed).

Both the histogram of standardized residuals (Figure 5) and the normal P-P plot (Figure 4) indicated by their shapes that all requirements for the normally distributed residuals were met. Additionally, the scatterplot of regression standardized residuals (Figure 6) showed a fairly evenly distributed set of points, indicating that the data met the assumptions of homogeneity of variance and linearity. The Durbin-Watson statistic was computed to evaluate independence of errors. The data met the assumption of independent errors (Durbin-Watson value = 2.17). All assumptions of statistical testing were met, indicating results of this multiple regression were reliable.

Figure 4

Normal P-P Plot of Regression Standardized Residual of Skills (Dependent Variable) and Knowledge (Independent Variable)



Research Question 3

What is the relative influence of membership in the APT on attitudes, knowledge, and skills of play therapy between the two groups of counselors (those with and those without APT membership)? I conducted an independent-samples *t* test to assess whether APT membership made a difference in counselors' attitudes, knowledge, and skills in play therapy (see Table 17). The hypothesis was that counselors with APT membership would have significantly higher attitudes, knowledge, and skills than counselors without APT membership, as measured by the mean scores of the PTAKSS-R subsets (Kao, 2009).

Table 17

Independent-Samples t Test Between Mean Scores for Association for Play Therapy Members and Nonmembers

Variable	*M*	*SD*	*t*	*p*	Cohen's *d*
Attitudes			1.43	.377	.324
Member	4.45	0.337			
Nonmember	4.40	0.241			
Knowledge			9.46	.000***	.505
Member	4.24	0.462			
Nonmember	3.50	0.705			
Skills			8.51	.000***	.488
Member	4.41	0.427			
Nonmember	3.77	0.749			

***$p < .001$.

The effect size statistic (*d*), was found to be .51 for knowledge and .49 for skills, indicating a difference and considered to have a medium effect size. Statistical significance was found for knowledge and skills, but not for attitudes. Therefore, the null hypothesis for attitudes must be accepted, and the null hypothesis for knowledge and skills must be rejected. Results from the *t* test partially supported Hypothesis 4 for Research Question 3 as the data uncovered significant relationships. APT membership made a difference in the knowledge and skills subsets.

Psychometrics from this study on the PTAKSS-R showed high internal consistency reliability (alpha = .96). The Cronbach's alpha was also calculated for the subscales, which yielded a score of .85 for the attitude subscale, .93 for the knowledge subscale, and .96 for the skills subscale. These reliability coefficients indicate a high degree of reliability of obtained results for the instrument. The reliability results presented are consistent with the findings from other studies of play therapy (Lindo et al., 2016; Muro et al., 2015; Perryman et al., 2017;

Thanasiu et al., 2018). These reliability results indicated that the PTAKSS-R was a sound measurement tool.

Discussion

In this study, the author assessed relationships between professional development, such as training in play therapy and professional association membership in APT, and attitudes, knowledge, and skills for licensed counselors and elementary school counselors who work with children 3–12 years of age in the United States. Each research question was analyzed with statistical measures, and the results were revealed.

The data from the MANOVA showed a relationship between university coursework in play therapy and attitudes, knowledge, and skills at a statistically significant level. Both knowledge and skills correlated at a statistically significant level with workshop training and institute/professional conference training, respectively, but not with attitudes. Results from the multiple regression analysis revealed play therapy workshop training was the highest predictor of increased knowledge, and institute/professional conference training was the highest predictor of increased skills, both at statistically significant levels. A combination of all three training types was a predictor of attitudes. The data output indicated a strong positive relationship between knowledge and skills and a linear relationship between knowledge and skills, suggesting that knowledge predicts skills in play therapy. Another finding was that professional organization membership in APT had the greatest influence on knowledge and skills but not on attitudes.

This study held a wide geographical representation, as counselors from all 50 states in the United States participated. Different types of professional counselors, at 80% of the sample, were, therefore, represented from the various licensures throughout the United States. Elementary school counselors from across the nation comprised the other 20% of the sample.

The study gave a voice to the current play therapy attitudes, knowledge, and skills of counselors who work with children 3–12 years of age. This research gave information based on training type in play therapy as measured by the PTAKSS-R, which is new information.

The statistical analysis results for this study were valid and reliable. According to the results, the goals and objectives of the research study were met. The hypotheses were tenable, and most retained results at the statistically significant level. The original thesis for the study was quantified in this chapter. New data and information were provided for counselor education and supervision programs in the United States. The results are interpreted in the implications in Chapter 5 regarding how the empirical data presented can benefit the field of counseling and the method of play therapy as an intervention.

Chapter 5

Summary, Implications, and Recommendations

This chapter discusses the findings from the present study on the relationship between professional development and attitudes, knowledge, and skills of play therapy among counselors. Limitations and implications of these results are covered, along with recommendations for future research in the field of counseling. The results have both theoretical and clinical implications, which are summarized in the implications section. In this chapter, I synthesize the information effectively to draw adequate conclusions.

Summary

The purpose of the study was to determine whether types of training and professional organization membership in the APT related to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors who work with children 3–12 years of age in the United States. Results provide a better understanding of the stated relationship among counselors who are real-life practitioners. Relatively few studies have addressed this topic for working counselors. The current body of empirical research on counselors who practice counseling was gravely lacking on the subject.

A thorough literature review was performed to recognize the contributions and efforts of previous researchers in the field who were interested in play therapy training or attitudes, knowledge, and skills of counselors. The review uncovered gaps in the literature where research was needed to make consequential contributions. Once these gaps were discovered, I identified an instrument, the PTAKSS-R (Kao, 2009), that would accurately align with the intent of the study, which was to quantify attitudes, knowledge, and skills in relation to various types of training modes and professional organization membership. The validity and reliability results of

this instrument were identified prior to sending out the survey for administration by participants. A pilot study was conducted preceding the current study to gain insights into the phenomenon.

After this study was proposed and all appropriate approvals were received, I sent posts to Facebook counselor/mental health groups with the survey link. These posts had to be approved by each group administrator. Emails with the survey link were later sent to all APT members on the roster, once approval was received from the APT. At the end of data collection, 333 met the study's criteria and completed the online survey. Hypothesis tests were run, and results were analyzed. The frequencies clearly indicated this was a highly qualified, highly educated, and highly credentialed sample of counselors in the area of play therapy. The majority of participants were APT members and held Registered Play Therapist credentials of some sort. The results indicated that APT members had higher levels of knowledge and skills in play therapy. All counselors, regardless of background or training, presented with high attitude scores.

The quantitative results suggested that these practicing counselors had high attitudes, knowledge, and skills in play therapy. Correlations were significant for all three subsets when correlated with university training, whereas only knowledge and skills were significant as related to institute/professional conferences and workshop training in play therapy. Based on the MANOVA results, university coursework influenced attitudes the most when compared with the other analyses in this study. Multiple regression results imparted that workshop training was the highest predictor of knowledge, whereas institute/conference training most predicted skills for counselors. All three types of training combined predicted higher attitudes. Perhaps transformational learning theory is applicable in this sense. Training counselors in play therapy is influential for the learner to reconstruct new knowledge that changes their worldview or

approach to counseling children. This training experience is, therefore, transformational, especially at the attitudes level in a university setting.

Limitations

To reiterate the applicable limitations from Chapter 1, researcher bias was one limitation in this study, as I am a Registered Play Therapist, professional counselor, and certified school counselor. I believe in extensive education and training, particularly at the graduate level, in play therapy for counselors who work with children. The intended population consisted of elementary school counselors and professional counselors throughout the United States; yet, many counselors who have no play therapy training were not included, and, therefore, the sample was not representative of the entire population (see Krathwohl, 2009). Even though the sample (N = 333) met the power analysis recommendation, the results were possibly not generalizable to the general population of counselors, and therefore, the study lacked external validity. APT members (85%) responded in larger numbers, whereas counselors with much less experience in play therapy or non-APT members (15%) participated in fewer numbers.

As the participants in this study were highly interested in play therapy with impressive credentials and professional development in play therapy, the results likely did not represent the overall population of counselors. Counselors without a background in play therapy likely were not interested in the study secondary to never having received information about play therapy at the university level. This could be in part due to lack of CACREP standards regarding counseling children, which limits exposure, incipient training, and understanding of how to meet the developmental needs of children in counseling sessions with play therapy. Therefore, some counselors were not able to recognize the importance of this topic and, thus, were not interested in a study on play therapy.

Lack of sampling framing was an additional limitation (see Fielding et al., 2008). Internet-based surveying lacks a sample frame because emails are generally available for a specific population, such as with the APT in this study. Facebook usage also leads to a possibility of lacking coverage area. Even though most people today have internet access, taking into consideration counselors who are not computer literate or simply do not participate on Facebook or other social media groups is important to remember. Lack of equal access on Facebook posting was a concern not only for those not participating in the counselor groups but also in regard to the timing of the posts. The researcher was concerned about who was able to see the post or not, based on random timing on each individual's feed.

Another limitation was that the instrument used, the PTAKSS-R, is a self-report assessment (Kao, 2009). This survey relied on the honesty of participants along with a risk of social desirability influences. Social desirability might have influenced the answers of respondents in ways that could not be detected (see DeVellis, 2017). Other extraneous factors, such as loss of interest or distraction, could have interfered with the results. Counselors might not have been able to participate because of heavy workloads that limited their time availability (see Shen, 2016).

The researcher included the term *undifferentiated* in the category under gender; however, SPSS did not categorize it in the results, which was puzzling. The total for men was 18 and the total for women was 315, but a total of 0 was not included in the results for undifferentiated; therefore, it was not reported in the descriptive data. Ethnicity and race were not included as part of the demographics. Inclusiveness in the study regarding a better understanding of those two variables was lacking (see Creswell & Creswell, 2018). As counselor education programs focus on multicultural and intercultural inclusiveness (CACREP, 2016), this might be considered

neglectful on the part of the researcher. The intent of this study, however, was focused on comparison between groups solely in relation to professional development.

An unexpected limitation for this study was in context of the COVID-19 world pandemic (CDC, 2020b). These uncertain times likely yielded uncertain results. Participants might not have been in the frame of mind to respond. This specific context might have reflected on the attitudes subscale, for example. Effects of the threatening virus on counselors' frame of mind might have limited respondents. Counselors might have been less in touch with their play therapy skills, as most were not meeting in person with children during the study period. Others might not have responded because of lack of interest in the topic secondary to focusing attention on more pressing matters at hand, like survival.

The researcher received approximately nine unsolicited email responses and four unsolicited posts that reported confusion over entering training hours. One counselor shared, "I completed the survey. I must say, I got confused on the 1st page questions about training hours. I wasn't sure if you needed a total or what." One person shared concerns about answering the survey items for attitudes because they pondered over how they would respond based on whether the child was emotionally health or emotionally disturbed. Another two participants expressed confusion over how to enter the education qualifications. The researcher responded to each email and post with careful consideration and assistance to remedy participant concerns. The qualifying question about working with children was a nonissue.

Communication with the participants aided them in responding, but the researcher was concerned about others who might not have communicated their confusion and responded haphazardly. In addition to confusion over how to input training hours, how to respond to attitudes, and how to enter education hours, participants expressed confusion over whether or not

to continue if they were from non-CACREP-affiliated university programs. Many counselors opted out of the survey when they reached Item 19, which asked whether or not counselors were graduates of a CACREP-accredited school. An estimated 45 participants were lost on Item 19. This was disappointing, as the research needed input from counselors who attended non-CACREP-accredited schools as well. Lack of clarification limited the sample diversity and external generalizability. Clarifying this piece in the recruitment email or post might have made a difference. Those from CACREP-accredited schools represented 71% of the sample, and those from non-CACREP-accredited schools represented 29%.

Internal validity was high in this study, as the claims or hypotheses were substantiated in the findings. The hypotheses considered in this study were the following:

H1. Counselors with university-level training will have higher levels of attitude, knowledge, and skills at a statistically significant level.

H2. Increased number of hours in university training will predict higher attitudes, knowledge, and skills at a statistically significant level.

H3. Knowledge in play therapy will predict skill level of the counselor at a statistically significant level.

H4. Counselors with APT membership will have statistically significantly higher attitudes, knowledge, and skills than counselors without APT membership.

In *H1*, counselors with university-level training had higher levels of attitudes, knowledge, and skills at a statistically significant level. The null hypothesis was rejected. For *H2*, however, the null hypothesis could not be rejected, since the university hours alone did not predict higher attitudes, knowledge, and skills at a statistically significant level. *H3* was the hypothesis most closely correlated and predictive in the study. Knowledge in play therapy predicted high skill

levels of the counselors at a statistically significant level. The null hypothesis was rejected. In *H4*, counselors with APT membership had higher levels of knowledge and skills at a statistically significant level; therefore, the null hypothesis was rejected. Counselors with APT membership, however, did not have higher attitudes. This part of the hypothesis was accepted as null.

Despite the limitations outlined above, this study expanded the body of research in the field of play therapy. It provided empirical data about attitudes, knowledge, and skills as related to professional development in play therapy. The study captured a broad representation of geographical locations, counseling licensures, number of years in counseling, and ages of counselors, throughout the United States. The study was a first-of-its-kind project to include licensed counselors at 80% of the sample. Heretofore, this mental health group had been practically invisible in past research and publication.

Elementary school counselors carried the other 20% of the sample, with five of those participants being School Based-Registered Play Therapists. This was impressive because the School Based-Registered Play Therapist credential is very new. The credential was launched in 2016; therefore, few school counselors are credentialed yet in this area (Hudspeth, 2016). As of September 3, 2020, the APT reported that there are 28 School Based-Registered Play Therapists, 2,037 Registered Play Therapist-Supervisors, and 2,642 Registered Play Therapists. See Appendix B for correspondence with the APT. In this study, 18% of School Based-Registered Play Therapists, 5% of Registered Play Therapists, and 5% of Registered Play Therapist-Supervisors responded to the survey.

Implications

The key implication in this study was that professional development in play therapy influences attitudes, knowledge, and skills in play therapy among counselors. Given the

relationship between university coursework and the three subsets, the implication is that if counselors receive instruction in play therapy at the graduate level in counseling programs, they will enter the profession with higher attitudes, knowledge, and skills in play therapy and, therefore, be more prepared to counsel children 3–12 years of age. Additionally, training through institutes, conferences and workshops as well as APT membership unveiled significant improvement in play therapy knowledge and skills. The implication here is that more professional development in these areas or modes is needed.

Another implication is that because many universities do not offer play therapy training, at this point, counselors seek institute/professional conference and workshop training to obtain the knowledge and skills needed to counsel young children. This was implicated by the result that 41% of this highly credentialed sample had no university coursework in play therapy, compared with 14% who had no institute/professional conference training and only 10% with no workshop training in play therapy. In other words, more counselors received institute/professional conference and workshop training in play therapy than university coursework in play therapy. Again, counselor education programs at the university level could better prepare counselors to work with children by providing play therapy coursework and instruction.

When the data were disaggregated in my current study, 44% of elementary school counselors, 24% who were licensed and elementary school counselors combined, and 42% of licensed counselors reported no university coursework in play therapy. Among this sample, elementary school counselors had the largest percentage with no university coursework in play therapy. Moreover, 56% of the elementary school counselors surveyed had no institute/professional conference training, and 30% had no workshop training in play therapy.

Again, elementary school counselors hold less institute/conference and workshop training in play therapy when compared with the other two groups. Of licensed counselors who were also elementary school counselors, 12% had no institute/professional conference training and 15% had no workshop training in play therapy. An implication may be that if elementary school counselors have a license in counseling, they retrieve more training in play therapy after graduating from university. Of the licensed counselors, only 10% had no institute/conference training and 7% had no workshop training in play therapy.

These results supported the thesis that counselors receive inadequate university coursework training in play therapy, through university counselor education programs, and therefore must actively seek out play therapy training from institute/professional conferences and workshops to acquire the skills needed to meet developmental needs of children they counsel. The data also made prominent the lack of training in play therapy that elementary school counselors receive when compared with licensed counselors. This information, therefore, suggests a need for more professional development training programs in play therapy, particularly for school counselors.

Though there were no emails or posts from participants recommending further research, some participants expressed gratitude for this research project because it placed focus on play therapy. The counselors shared that they appreciated research being conducted in the area of play therapy. One participant stated, “Thank you for adding to the play therapy research base. . . . . Best wishes. . . . Work hard and play harder!” This attitude of excitement reinforced the idea that APT leadership, APT members, and those who believe in the effectiveness of play therapy with children want and need more research to be published.

Literature Review Comparisons

One common assumption in the literature review was that play therapy requires a great deal of training for the counselor to be effective and to ensure competent services. This assumption was tested throughout the statistical analyses. The results conveyed that for knowledge and skills to be high, the counselor must receive adequate training. Training did not seem to be as pressing for attitudes, except training at the university level. This was where testing revealed the most correlation. Institute/conference and workshop training did not impact attitudes so much as they impacted skills and knowledge, respectively.

When comparing this current study to prior research, only one study addressed relationships between training and attitudes, knowledge, and skill in play therapy for licensed professional counselors. Carnes-Holt and Weatherford (2013) conducted a 2-day play therapy workshop training in a rural setting and then examined attitudes, knowledge, and skills of real-world practitioners. The PTAKSS was administered pretest, midpoint, and posttest. Though means in each area increased, no statistically significant findings were reported. Due to such a paucity of literature published in this area, it is difficult to connect this current study to prior research for licensed counselors.

No studies have been published on a combination of licensed counselors and elementary school counselors as participants. Aside from the data in my pilot study (Anderson, 2019), *Attitudes, Knowledge, and Skills of Play Therapy Among Elementary School Counselors*, which is not published yet, one study utilized the PTAKSS to examine attitudes, knowledge, and skills of school counselors. Kagan and Landreth (2009) determined effects of short-term play therapy training with school counselors. The results of their experimental study demonstrated statistically significant improvement in knowledge but not in skills or attitudes. My pilot study indicated that

university-level training in play therapy related most closely to the knowledge that school counselors have about play therapy (Anderson, 2019). This current study showed that university-level training in play therapy correlated with attitudes, knowledge, and skills. It also demonstrated that institute/professional conference and workshop training in play therapy related to higher levels of knowledge and skills, but not attitudes.

The elementary school counselors in my pilot study sample reported positive attitudes towards children and play therapy regardless of level of training (Anderson, 2019). Of 21 participants in the study, 11 had no training in play therapy. On a 1–5 Likert scale, the mean for the attitudes scale score was 4.39, for knowledge scale score was 2.93, and for the skills scale score was 2.95. My current study resulted in overall higher mean scores, aside from attitudes. Attitudes remained fairly consistent between the two studies. The means for the current study attitudes scale score ($M = 4.44$, $SD = 0.32$), knowledge scale score ($M = 4.13$, $SD = 0.57$), and skills scale score ($M = 4.31$, $SD = 0.54$) revealed that these counselors reported high levels of attitude, knowledge, and skills in play therapy. Data from my pilot study suggested that the more knowledge a counselor has in play therapy, the more confidence the counselor will have in play therapy skills. This was an area of high consistency with my current study. The multiple regression analysis resulted in knowledge being a predictor of reported skill level.

The current body of knowledge on training in play therapy showed that counselors demonstrated statistically significantly increased knowledge and skills of play therapy through training (Carnes-Holt & Weatherford, 2013; Flasch et al., 2017; Kagan & Landreth, 2009; Pereira & Smith-Adcock, 2013), but there were no statistically significant findings regarding improvement in counselor attitudes (Kagan & Landreth, 2009). Attitude was often not mentioned in results of the studies reviewed. This could be in part because counselors tend to begin with a

good attitude and, therefore, their attitude remains the same (Pereira & Smith-Adcock, 2013). These findings were somewhat reflected in my study, as attitudes were not related to institute/professional conference or workshop training, and APT membership influenced counselors' knowledge and skill in play therapy but not attitudes. There were two exceptions, however, where attitudes correlated at a statistically significant level with training. University coursework correlated with attitudes in play therapy, and a combination of the three training types predicted attitudes. These are new findings in play therapy research.

Consistent with previous research, Shin and Gonzalez (2018) reported that school counselors do not have an opportunity to take graduate-level coursework in play therapy. The CACREP standards are simply deficient in providing a model for counseling children. Shin and Gonzalez explained that counselors then seek out workshop training or individual study to obtain their goals of working effectively with children. Ray et al. (2005) reinforced this idea by revealing that 67% of elementary school counselors had not received university coursework in play therapy, even though they were interested in the topic. In my study, 44% of participants who selected the elementary school counselor qualifier alone had not received university coursework in play therapy. Perhaps this sample of counselors attended universities where more play therapy was offered or they responded because they had a foundation in play therapy.

As no studies addressed number of institute/professional conference hours counselors receive, I was unable to make comparisons. Ryan et al. (2002) mentioned that 19.4% of APT members surveyed had fewer than 25 hr of workshop training. Comparisons were difficult here as well, especially since those participants were from various mental health disciplines. The results from this current study gave new information in the areas of institute/professional conference and workshop training in play therapy for counselors.

No studies in the literature were available with which to compare results from the *t* test of independent samples between group counselors with and without APT membership as related to attitudes, knowledge, and skills of play therapy. Lambert et al. (2007) compared APT members with American Counseling Association members regarding play therapy training hours but did not focus on attitudes, knowledge, and skills in play therapy. The paucity of research published comparing the two groups in this study made it difficult to connect the findings to prior research for licensed counselors and elementary school counselors. The results from this study, therefore, provide new information and empirical data to professionals in APT and counselor education.

Transformational Learning Theory

A theoretical implication gained from the data is that the theory guiding this study, transformational learning theory, is integral to the results. Transformational learning theory is an andragogy that purports forums for learning such as higher education or professional development construct new knowledge that can be applied in practice (Mezirow, 2004). The results indicated knowledge predicts skill level in play therapy, a defining link between the study and the theory. In the correlation results, university coursework in play therapy was related to all three subsets at a statistically significant level. Perhaps gaining knowledge at the university level transforms not only knowledge level but also counseling students' attitudes and skills. Transformational learning theory (Mezirow, 2004) values knowledge that enhances attitudes, values, beliefs, and skills in the topic studied (Fazio-Griffith & Ballard, 2016).

Additionally, since elementary school counselors held the least amount of professional training hours in play therapy, a need was indicated. Transformational learning theory supports the idea that additional professional development could assist elementary school counselors in better meeting the emotional and developmental needs of children in school with the use of play

therapy methods. Professional development at the workshop level could increase knowledge, and institute/professional conference training could increase skills, as indicated in the multiple regression results of this study. This training could be expanded to teachers, administrators, and parents in a multidisciplinary approach for obtaining additional tools for reaching children.

The results suggested that APT members had higher levels of knowledge and skills, so transformational learning theory could be applied to professional organization membership to provide those learning opportunities. The APT offers various professional conference opportunities. The results of the multiple regression in this study revealed that professional conferences predict higher levels of skills in play therapy for counselors. Transformational learning theory claims that learning forums such as professional development construct new knowledge that can be applied in practice with skills (Merriam, 2004).

In counselor education, transformation learning theory serves to increase positive counseling outcomes for all people (Henriksen, 2006). Leaders and faculty in counselor education programs could examine the results of this study and other studies cited in this manuscript to recognize the need that counselors have for increasing their attitudes, knowledge, and skills of play therapy to counsel children more effectively. What is learned in higher education play therapy coursework then could be used in direct application in the active work of counseling children (Muro et al., 2015).

Recommendations

The research on play therapy; professional development and training; and attitudes, knowledge, and skills in play therapy needs to be examined more broadly. Further research that includes more counselors who do not have training in play therapy could give a better comparison between groups. Studies that include a broader population of counselors could help

give greater contrast and clearer insights. In this study, counselors reported that professional development, whether through training or professional organization membership, related significantly to higher attitudes, knowledge, and skills. What about counselors who do not have this level of professional development in play therapy? Are they as prepared to counsel young children? Readiness for counseling children could be another area to examine or explore in this realm. Quantitative research could examine counselors' experiences entering the field and their self-perceived comfort and readiness counseling children as related to play therapy training.

Qualitative research could explore the lived experiences of counselors entering the profession regarding their comfort with counseling children. This might give a richer description of the feelings and fears associated with counseling young children without the proper preparation. A qualitative research project might capture the urgency counselors feel in needing the attitudes, knowledge, and skills in play therapy to meet the developmental needs of children, or maybe it would not, which would be interesting as well.

This current study focused on counselors from counseling programs, yet there was overwhelming interest and support from other mental health disciplines such as licensed marriage and family therapists, licensed social workers, and licensed clinical psychologists. One psychologist emailed an unsolicited response sharing that they were a clinical psychologist who worked with school children with emotional disabilities. The psychologist stated, "Your study does not include psychologists, trained in play therapy, and as such you will be missing some important data." Approximately 30 emails were received from members of the various mental health professions who inquired about participating but who did not meet the qualifier. The researcher attempted to respond to all inquiries by giving a professional explanation and expressing appreciation.

Due to considerable interest from various other mental health disciplines, beside counselors from counseling programs, a study of this sort could be expanded to include the different licensed social workers, licensed marriage and family therapists, clinical psychologists, professors in the mental health field, and perhaps interns and students. The APT might be interested not only in this current study, focused on counselors from graduate-level counseling programs, but also in a study including all of the diverse membership credentials and licensures within the organization.

The new findings of my study will be important to the field of counseling and the APT membership organization. APT members were found to have higher knowledge and skill of play therapy at a statistically significant level, although not for the subset of attitudes, which showed little difference. When scrutinizing the results of this data, membership in APT could be recommended for professional development to improve both knowledge and skills in play therapy. Additionally, the APT will be interested in knowing that the need for a School Based-Registered Play Therapy was quantified in this data set. This research supports the credential along with the necessity for increased training in play therapy for elementary school counselors. Faculty in school counseling university programs may want to pay close attention to the play therapy research presented. The CACREP also can take notice of an area of vulnerability revealed in this research because of lack of written standards for counseling young children.

The data from this study shed light on elementary school counselors' need for increased training in play therapy. Counselor educators could help to build a stronger foundation in school counseling education programs by providing play therapy courses or, at least, incorporating play therapy into the coursework. The CACREP could incorporate play therapy methods into the standards or, at a minimum, include standards for counseling children. All of this, in turn, could

assist elementary school counselors in better meeting children's needs in counseling. Additionally, more professional development in play therapy via institutes, professional conferences, and workshops could better meet the needs of elementary school counselors; perhaps simply promoting play therapy training availability could help reach more of these school counselors.

The results from the *t* tests between subjects showed that APT members had higher knowledge and skills in play therapy. Professional organization membership makes a difference. The researcher wondered, though, if counselors with advanced training, knowledge, skills, and experience in play therapy are more likely to be APT members or if the members are afforded more training opportunities through their involvement, which then gives them more advanced knowledge and skills. This could be an area for further quantitative and qualitative research.

The present study compared relationships between professional development in play therapy and attitudes, knowledge, and skills of counselors. The findings suggested a relationship. The study revealed that university coursework in play therapy was related to higher attitudes, knowledge, and skills. Further, university coursework in combination with the institute/professional conference and workshop training in play therapy predicted increased levels in attitudes, knowledge, and skills. The recommendation from these correlations is for more university counseling programs to offer play therapy coursework to give counselors a stronger foundation for counseling children.

All of this new information can provide counselors with data needed in their quest for professional development choices, can offer credentialing bodies empirical research for decision-making, and may encourage counselor educators to include play therapy in their coursework or elective offerings. More counselors who work with children 3–12 years of age may want to

explore play therapy as a method and therefore engage in more play therapy professional development based on the results of this study. Ultimately, this research can contribute to better meeting the growing imperative that more children need counseling and, thus, can help counselors meet those children's needs through professional development. Further research in this area could augment the knowledge, information, and data available to counselors for more evidence-based practices in the field of counseling and play therapy.

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Figure 5

Simple Regression Analysis Histogram: Knowledge as Predictor of Skills

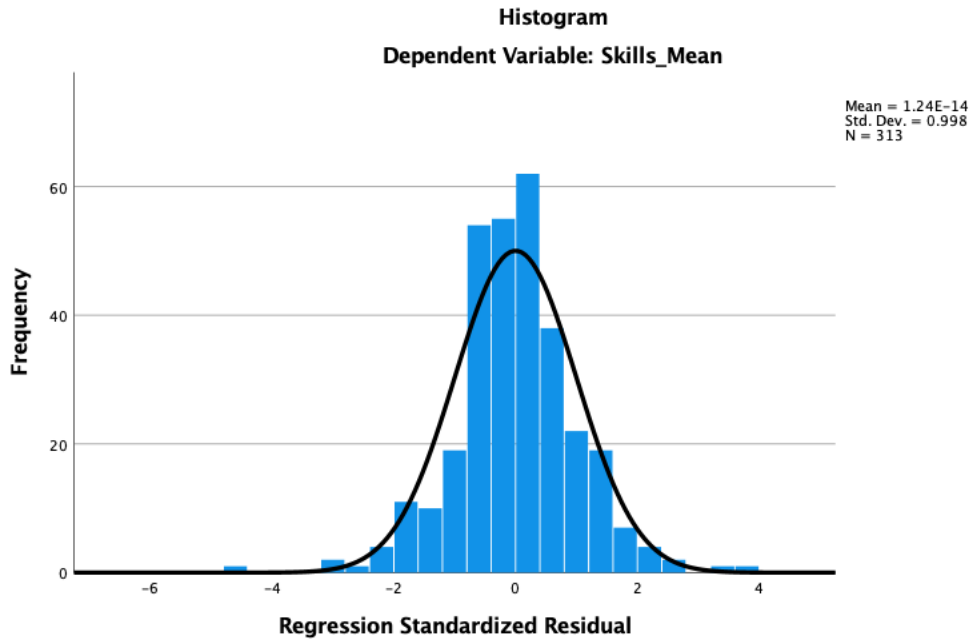


Figure 6

Simple Regression Scatterplot: Knowledge as Predictor of Skills

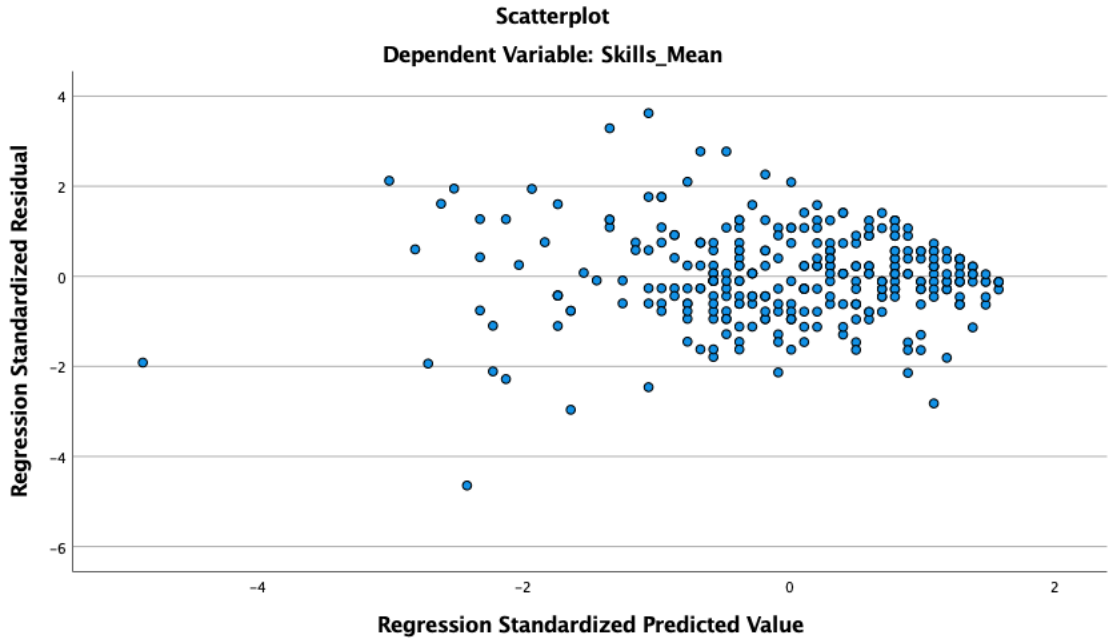


Figure 7

Multiple Regression Analysis Histogram: Attitudes (Dependent Variable) and Training Types (Independent Variable)

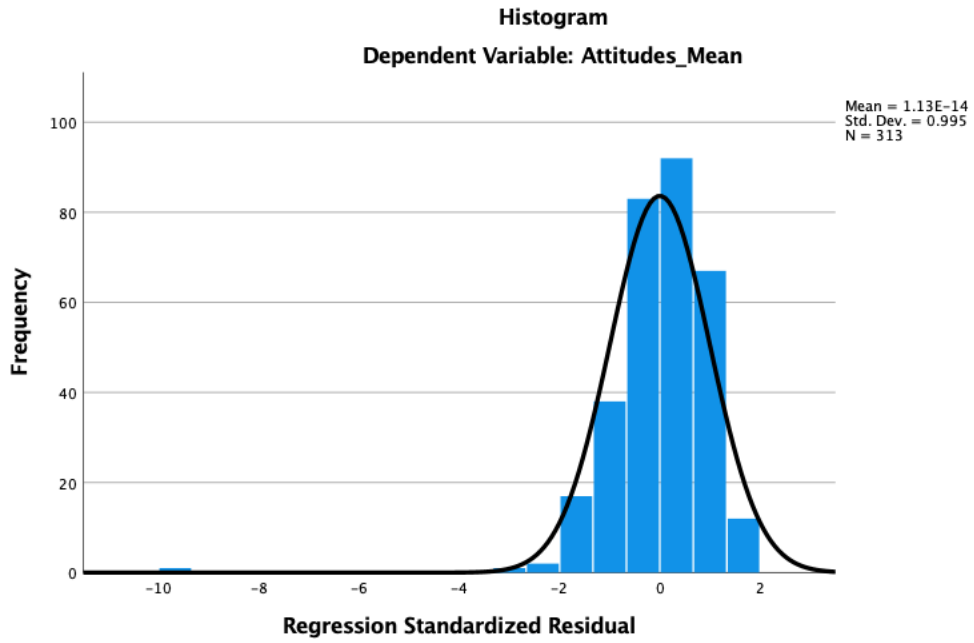


Figure 8

Multiple Regression Analysis Scatterplot: Attitudes (Dependent Variable) and Training Types (Independent Variable)

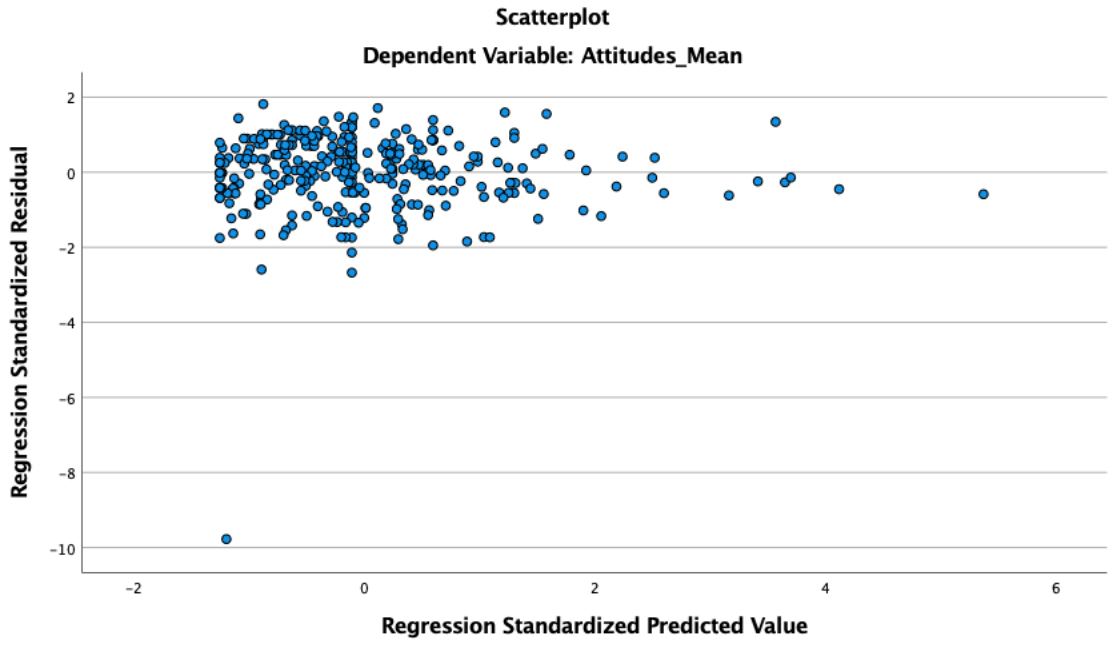


Figure 9

Multiple Regression Analysis Histogram: Knowledge (Dependent Variable) and Training Types (Independent Variable)

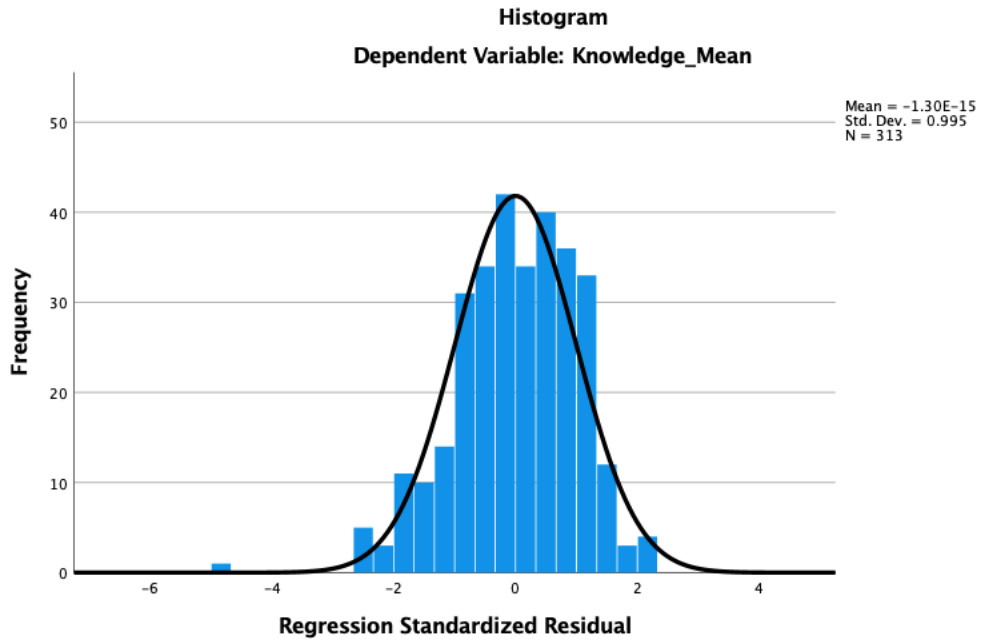


Figure 10

Multiple Regression Analysis Scatterplot: Knowledge (Dependent Variable) and Training Types (Independent Variable)

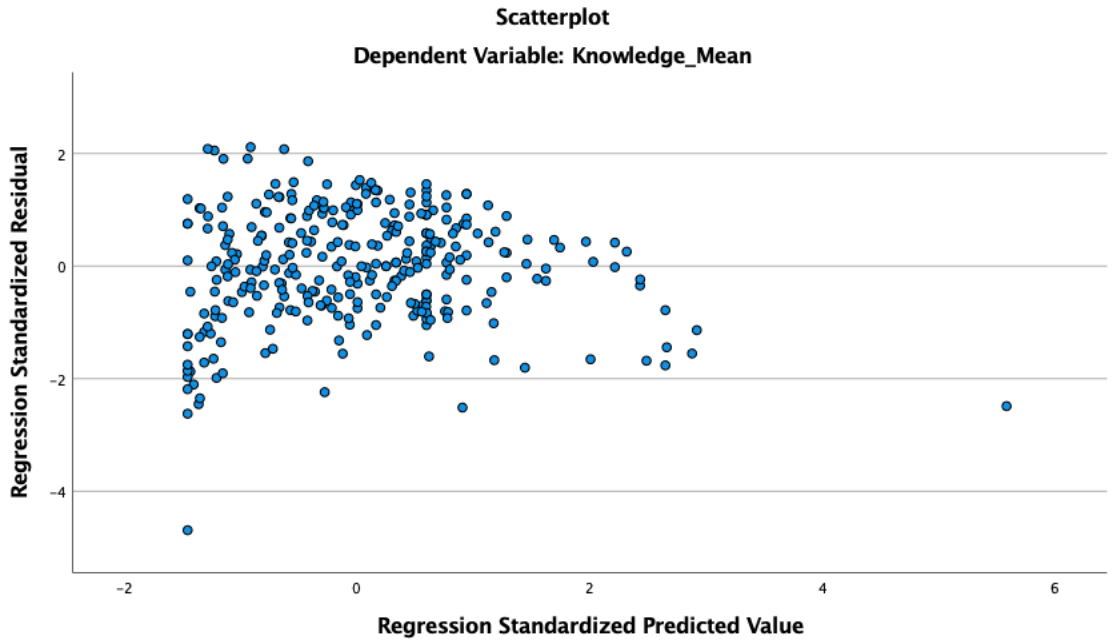


Figure 11

Multiple Regression Analysis Histogram: Skills (Dependent Variable) and Training Types (Independent Variable)

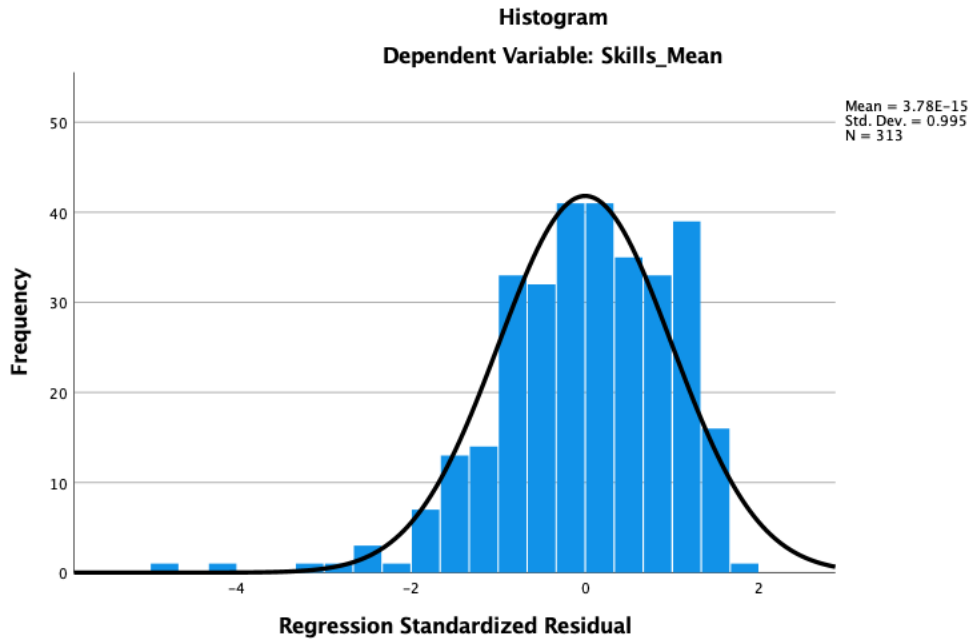
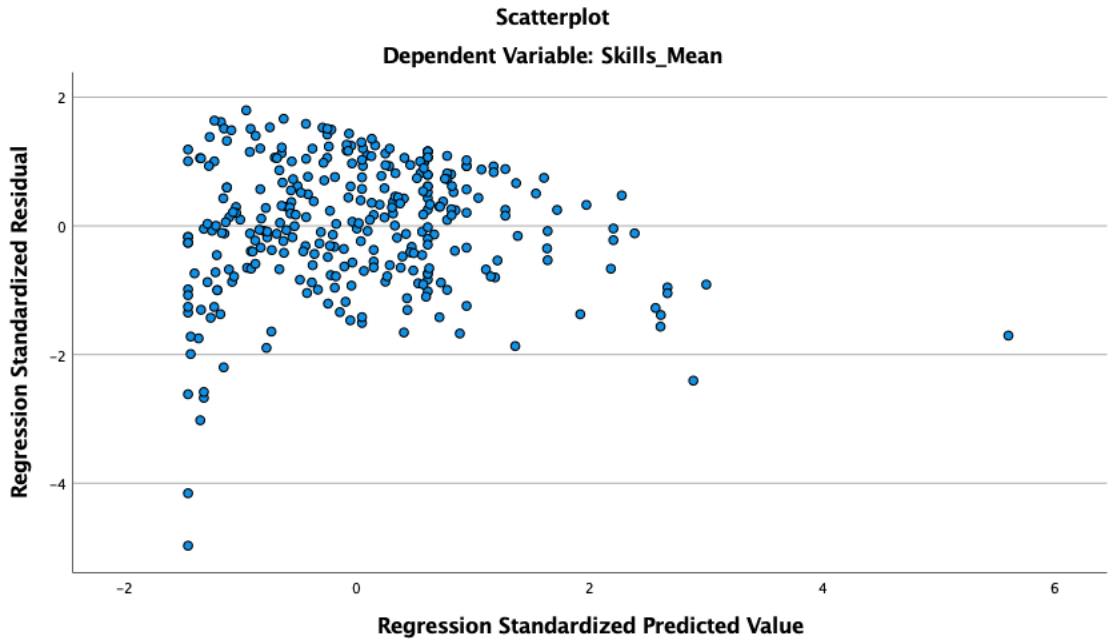


Figure 12

Multiple Regression Analysis Scatterplot: Skills (Dependent Variable) and Training Types (Independent Variable)



Appendix A
Survey Packet

Informed Consent

Relationships Between Professional Development and Attitudes, Knowledge, and Skills in Play Therapy Among Counselors
St. Mary's University San Antonio, Texas

Please read this consent document carefully before you decide to participate in this study. If you have any questions prior to completing the survey, you may contact the researcher, Cynthia Anderson, at canderson14@mail.stmarytx.edu, or her dissertation chair, Dr. Reyna-Vasquez at preyna1@stmarytx.edu.

Purpose of the research study:

The purpose of this proposed study is to determine which types of training and whether professional organization membership in play therapy relate to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors who work with children 3-12 years of age in the U.S.

What you will be asked to do in the study:

If you choose to participate, you will answer questions about your self-perceived attitudes, knowledge, and skills of play therapy methods with the children that you counsel or plan to counsel. The survey should take approximately 10-15 minutes.

Risks and Benefits:

The risks of the study are minimal. The potential benefits of the study include that you will be making a difference for professional counselors and elementary school counselors, particularly in the field of play therapy by participating in research that will contribute to the profession. You will also learn more about your own attitudes, knowledge, and confidence in applying play therapy skills.

Incentive or Compensation:

There is no incentive for participating; therefore, you will not be adversely affected in any way if you choose not to participate.

Anonymity:

Appendix A (cont.)

The survey is anonymous, so the researcher has no way of knowing your identity. In order to maintain your own privacy, please take the survey in a quiet, secure area.

Voluntary participation:

Your participation in this study is completely voluntary. There is no penalty or loss of benefit for choosing not to participate.

Right to withdraw from the study:

You have the right to withdraw from the study at any time without consequence or penalty.

Whom to contact if you have concerns about the study:
If you have any questions about your rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

Agreement:
I wish to participate
or
I do not wish to participate

Qualifying Question

- I am a professional counselor who is licensed (fill in the blank for type of license) in the U.S.
- I am an elementary school counselor in the U.S.

Qualifying Question

- I have counseled children 3-12 years of age
- I will counsel (have not yet) children 3-12 years of age
- I currently counsel children 3-12 years of age

Part I: Play Therapy Attitude-Knowledge-Skills Survey Revised (Demographics)

Gender

- Male
- Female
- Undifferentiated

Appendix A (cont.)

Age

- 21-35
- 36-50
- 51+

Education

- School Counselor Certification
- Master's in Counseling
- Professional Counselor who is licensed
- Doctoral Student in Counseling
- Doctoral Degree in Counseling
- Registered Play Therapist™
- School Based-Registered Play Therapist™
- Registered Play Therapist-Supervisor™

Training in Play Therapy

University credit hours for a course that included play therapy training (Use 0 for no hours)

Institute and / or conference training hours in play therapy (multi-day) (Use 0 for no hours)

Play Therapy workshop training hours (1 day or shorter) (Use 0 for no hours)

*State in the U.S. where you practice or work*_____

Number of years in counseling

- 0-5 years
- 6-12 years
- 13-20 years
- 20+ years

Are you an Association for Play Therapy (APT) member?

- Yes
- No

Appendix A (cont.)

Did you graduate from a CACREP accredited program?

- Yes
- No

Part II: Play Therapy Attitude-Knowledge-Skills Survey Revised

From the available choices, please circle one that best fits your response to each question.

	1 - strongly disagree	2 - disagree	3 - neither agree nor disagree	4 - agree	5 - strongly agree
1. I am willing to and like to work with children.	1	2	3	4	5
2. I am accepting of the child part of myself.	1	2	3	4	5
3. I enter new relationships with children with confidence and relaxation.	1	2	3	4	5
4. I am a warm and friendly person to children.	1	2	3	4	5
5. Children need to be given correct answers to questions.	1	2	3	4	5
6. I have a high tolerance for ambiguity.	1	2	3	4	5
7. I know myself and accept myself as who I am.	1	2	3	4	5
8. I greatly respect children's basic rights.	1	2	3	4	5
9. I have a sense that children trust me.	1	2	3	4	5
10. Children possess a tremendous capacity to overcome obstacles and circumstances in their lives.	1	2	3	4	5
11. Children experience the depth of inner emotions that adults are capable of experiencing.	1	2	3	4	5
12. Children are capable of positive self-direction if given an opportunity to do so.	1	2	3	4	5
13. Children are capable of figuring things out.	1	2	3	4	5

	1 - strongly disagree	2 - disagree	3 - neither agree nor disagree	4 - agree	5 - strongly agree
14. Children tend to make the right decision.	1	2	3	4	5
15. I have more patience with children than other people do.	1	2	3	4	5
16. A good therapeutic relationship is the most important foundation for helping children change.	1	2	3	4	5
17. I find joy in helping people when working with children.	1	2	3	4	5
18. I look forward with pleasure to helping children grow.	1	2	3	4	5
19. I think highly of remaining curious and open to new and playful things.	1	2	3	4	5
20. Play is good for physical and mental health.	1	2	3	4	5
21. Children's emotional disturbance problems are not due to lack of education and training.	1	2	3	4	5
22. I often get great inspiration from children.	1	2	3	4	5
23. Children don't need direction from a counselor to work out solutions to their own problems in a counseling relationship.	1	2	3	4	5

	1 – none	2 – very limited	3 - limited	4 - good	5 – very good
24. How would you rate your knowledge of play therapy as an approach for counseling with children?	1	2	3	4	5
25. How would you rate your understanding of the reasons for selecting and excluding toys and materials in play therapy?	1	2	3	4	5

	1 – none	2 – very limited	3 - limited	4 - good	5 – very good
26. How would you rate your knowledge of how children communicate?	1	2	3	4	5
27. How would you rate your knowledge of identifying areas where limits should be set?	1	2	3	4	5
28. How would you rate your understanding of symbolic play in play therapy?	1	2	3	4	5
29. How would you rate your ability to consider the underlying meanings of children's questions?	1	2	3	4	5
	1	2	3	4	5
How do you rate your understanding of the following terms?					
30. Play theme.	1	2	3	4	5
31. Tracking.	1	2	3	4	5
32. Returning responsibility.	1	2	3	4	5
33. Therapeutic limit setting.	1	2	3	4	5
34. Choice giving.	1	2	3	4	5
35. Play materials.	1	2	3	4	5
36. Directive play therapy.	1	2	3	4	5
37. Non-directive play therapy.	1	2	3	4	5
38. Group play therapy.	1	2	3	4	5
39. Family play therapy.	1	2	3	4	5
40. Play therapy with adults.	1	2	3	4	5
41. Parent consultation.	1	2	3	4	5
42. How would you rate your ability to effectively assess the mental health needs of a child?	1	2	3	4	5
43. How would you rate your ability to distinguish differences in counseling adults and children?	1	2	3	4	5
44. How would you rate your ability to conduct a play therapy session with a child?	1	2	3	4	5
45. How would you rate your overall ability to relate to children?	1	2	3	4	5

	1 – none	2 – very limited	3 - limited	4 - good	5 – very good
46. How would you rate yourself in terms of being able to effectively deal with a silent child in play therapy?	1	2	3	4	5
47. How would you rate yourself in terms of being able to effectively deal with an aggressive child in play therapy?	1	2	3	4	5
48. How would you rate yourself in terms of being able to effectively deal with a reluctant or anxious child in play therapy?	1	2	3	4	5
49. How would you rate your ability to provide consultation to parents?	1	2	3	4	5
50. How would you rate your ability to help parents understand their children?	1	2	3	4	5
51. How would you rate your ability to critique a play therapy session?	1	2	3	4	5
52. How well do you think you could identify play themes?	1	2	3	4	5
53. How would you rate your ability to help children understand themselves in play therapy?	1	2	3	4	5
54. How would you rate your ability to set limits on children's behavior in play therapy?	1	2	3	4	5
55. How would you rate your ability to establish a facilitative relationship with a child in play therapy?	1	2	3	4	5
56. How would you rate your ability to track a child's behaviors in play therapy?	1	2	3	4	5
57. How would you rate your ability to reflect children's feelings in play therapy?	1	2	3	4	5
58. How would you rate your ability to reflect the content of children’s play in play therapy?	1	2	3	4	5
59. How would you rate your ability to facilitate children's spontaneity and creativity in play therapy?	1	2	3	4	5
60. How would you rate your ability to facilitate decision-making and responsibility by children in play therapy?	1	2	3	4	5
61. How would you rate your ability to verbally match the affective and activity pace of a child in play therapy?	1	2	3	4	5

	1 – none	2 – very limited	3 - limited	4 - good	5 – very good
62. How would you rate your ability to be succinct and specific in communicating with children in play therapy?	1	2	3	4	5
63. How would you rate your ability for self-supervision of counseling relationships with children?	1	2	3	4	5

Appendix B
IRB Approval

ST MARY'S UNIVERSITY

July 22, 2020

Cynthia Anderson
Dept. of Counseling
St. Mary's University

DELIVERED BY EMAIL TRANSMISSION

Dear Ms. Anderson:

The IRB has approved the study, Anderson, C (Reyna-Vasquez, faculty sponsor). Relationships Between Professional Development and Attitudes, Knowledge, and Skills in Play Therapy Among Counselors. If research participants have any questions about their rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

Dan Ratliff, Ph.D.
IRB Chair
St. Mary's University

The proposal is determined to meet criteria for exemption under 45 CFR 46.104(d)(2), the use of survey procedures, interviews with de-identified, minimal risk data.

Exempt research does not require IRB review or renewal for five years (2025). However, IRB requests a closure report when the data collection is completed, or, if active data collection continues, a summary report of the sample size at the May IRB meeting of each academic year.

Exempt research can proceed with an abbreviated consent process in which the subjects are informed of the purpose and duration of the survey, and with no signature necessary for informed consent. The approval stamp must be visible in the information about the study provided to potential subjects.

You may collect data from human subjects according to the approved research protocol. The approval stamp must appear on any Information Form or Informed Consent Form approved by the IRB (jpeg file attached).

DEPARTMENT OF COUNSELING AND HUMAN SERVICES ■ ONE CAMINO SANTA MARIA ■ SAN ANTONIO, TEXAS 78228-8527
OFFICE: (210) 438-6400 ■ FAX: (210) 438-6441

ST MARY'S UNIVERSITY

If, at any time, you make changes to the research protocols that affect human participants, you must file a "Changes to Approved IRB Protocol and/or Unanticipated Problems" form. Changes must be reviewed and approved by IRB before proceeding with data collection.

Good work on an interesting approach to counselor education. I look forward to seeing your results.

Dan Ratliff, Ph.D.
IRB Chair

CC: Priscilla Reyna-Vasquez, PhD, Faculty Sponsor
Melanie Harper, PhD, IRB Area Representative
Attachment: IRB Approval Stamp jpeg file

Appendix C
Recruitment Email Message or Post

Re: Dissertation Research in Play Therapy
Relationships Between Professional Development and Attitudes, Knowledge, and Skills in Play Therapy Among Counselors
Please help me graduate by completing this survey!

Calling for ***Professional Counselors (who are licensed)*** and ***Elementary School Counselors*** in the ***U.S.***
I am particularly interested in feedback from those of you who have/will/do ***work with children 3-12 years of age.***
If you meet that criteria, I am very interested in getting your feedback about your attitudes, knowledge, and skills of play therapy. ***Your input is needed!***

Dear Participants,
You are invited to participate in a study being conducted by Cynthia Anderson, a doctoral student in Counselor Education and Supervision at St. Mary's University in San Antonio, Texas. The survey will take approximately 10-15 minutes. If you have any questions prior to taking the survey, please contact the researcher, Cynthia Anderson at canderson14@mail.stmarytx.edu, or dissertation chair, Priscilla Reyna-Vasquez, PhD. at preyna1@stmarytx.edu.

BENEFITS & RISKS
Your responses will help us learn more about which types of training and whether professional organization membership in play therapy relate to higher levels of attitudes, knowledge, and skills for professional counselors and elementary school counselors who work with children 3-12 years of age in the U.S. ***You will be making a difference in the field as you contribute to needed research.*** There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life.

ANONYMOUS SURVEY
Your survey answers will be stored in a password protected electronic format. No names or identifying information will be included in any publications or presentations based on these data.

CONTACT
If you have any questions about your rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

Please click on link:

http://stmarys.az1.qualtrics.com/jfe/form/SV_8oyjuNVyDAYiskJ

Thank you so much,
Cynthia Anderson, MEd, LPC, RPT, CSC

Appendix D
Correspondence and Permissions

Obtained Survey for Pilot Study

Initial permission to use the instrument PTAKSS-R from the University of North Texas.

From: Lindo, Natalya <Natalya.Lindo@unt.edu>
Sent: Monday, November 6, 2017 10:51:36 AM
To: Anderson, Cynthia
Subject: RE: [EXT] PTAKSS revised

Here you go Cynthia. In terms of your other questions, please feel free to contact Kao, the developer of the instrument. Good luck with your research,
Natalya

Natalya Ann Lindo, PhD, LPC
Associate Professor & Program Coordinator
Counseling and Higher Education
University of North Texas
1155 Union Circle, # 310829
Denton, TX, 76203-5017
Tel: 940-565-2915
Fax: 940-565-2905
Email: Natalya.Lindo@unt.edu

Email is not a confidential medium. Please contact me by telephone if privacy is essential.

From: Anderson, Cynthia [mailto:canderson14@mail.stmarytx.edu]
Sent: Saturday, November 4, 2017 6:19 PM
To: Lindo, Natalya <Natalya.Lindo@unt.edu>
Subject: [EXT] PTAKSS revised

Hi Dr Lindo,

My name is Cynthia Anderson and I am in the CES PhD program at St. Mary's University in San Antonio, Texas. My research project is in play therapy. I am needing a copy of the PTAKSS revised. If you could help me with that, I would appreciate it. Also, I was wondering if the PTAKSS revised has had a factor analysis performed on it. If not, my professor would like for me to run a factor analysis on the instrument for the first phase of my research.

Also, I have read some of your articles and appreciate the work you have done in the field. Thank you!

Sincerely, Cynthia Anderson

Appendix D (cont.)

Purpose of PTAKSS and PTAKSS-R Instruments

Landreth, Garry <Garry.Landreth@unt.edu>
Tue 3/24/2020 5:12 PM

The PTAKSS is not a competencies scale. It is a measure of the individual's perception of their attitudes, knowledge, and skills. You might want to contact Dr. Natalya Lindo for updated information about the PTAKSS.

Hope your study goes well.

Garry

Anderson, Cynthia
Wed 3/4/2020 4:02 PM

Dear Dr. Landreth,
I am a doctoral student at St. Mary's University doing a validation study on the PTAKSS-R instrument.
I'm curious as to whether the survey measures competencies?
The studies I have read indicate that the PTAKSS and PTAKSS-R were created to measure attitudes, knowledge, and skills of play therapy after training in play therapy has occurred.
Would that be considered competencies after training?
CACREP talks about training counselors to be competent with professional disposition, knowledge, and skills.
The participants in my study will be practicing counselors (LPCs and School Counselors.)
I am wondering if I should gear my study toward measuring competencies (based on the PTAKSS-R) or state it as measuring attitudes, knowledge, and skills?
Your feedback would be greatly valued.
Thank you!
Cynthia Anderson, MEd, LPC, RPT

Permission from Author, Dr. Shu-Chen Kao, to Use Scales

This includes the Play Therapy Attitudes Knowledge and Skills Survey-Revised

(PTAKSS-R) e-mail authorization to be used in this study. The PTAKSS-R has been authorized

to be used in this study by the scales original author, Dr. Shu-Chen Kao.

Appendix D (cont.)

Anderson, Cynthia
Tue 11/7/2017 1:41 PM

- kaosc@mail.ksu.edu.tw

Hi Dr Kao,
I am Cynthia Anderson, a PhD student in Counselor Education at St Mary's University in San Antonio, Texas. I was wondering if you could give me permission to use the PTAKSS revised for my research? I would also like to do a factor analysis on the instrument.
Please let me know if you grant me permission.
Thank you,
Cynthia Anderson

Anderson, Cynthia
Mon 11/6/2017 2:37 PM

- Kao.ShuChen@unt.edu

Hi!
My name is Cynthia Anderson and I am working on my PhD in CES at St Mary's University in San Antonio, Texas. I would like to use the PTAKSS revised in my research and possibly conduct a factor analysis on the instrument. I need to get your permission for both projects.
Please let me know if this is possible.
Thank you!
Cynthia Anderson

Anderson, Cynthia
Tue 5/5/2020 1:09 PM

- sckao@cc.ncue.edu.tw

Hello Shu-Chen,
I am writing to ask your permission to use the PTAKSS-R in my dissertation research study on play therapy. I am a doctoral student at St. Mary's University in San Antonio, Texas. The title of my project is Play Therapy Attitudes, Knowledge, and Skills Among Counselors.
I look forward to hearing from you.
Thank you, Cynthia Anderson

Appendix D (cont.)

Anderson, Cynthia
Wed 5/6/2020 10:49 AM
Dr. Kao, Thank you so much! Cynthia Anderson St. Mary's University CES Get Outlook for iOS □

高淑貞 <sckao@cc.ncue.edu.tw>
Wed 5/6/2020 2:41 AM

- Anderson, Cynthia

□
Hi, Cynthia,

You're welcome to use the PTAKSS-R.
Good luck to your research project.

Shu-Chen Kao, Ph.D.
Professor, Department of Guidance & Counseling
Provost, National Changhua University of Education
TEL:886-4-7232105ext.5601
E-mail:sckao@cc.ncue.edu.tw

Establishment of the Center for Play Therapy and Search for Author

Landreth, Garry <garry.landreth@unt.edu>
Wed 3/25/2020 9:34 PM

- Anderson, Cynthia

□
Check with the Center for Play Therapy. They may have the Kao article. Also, Dr. Lindo may have a copy. You could put the reference in google and see what comes up.

I didn't have a graduate assistant who helped me set up the CPT. Dr. Emily Oe was my part time voluntary sec.
Garry

Appendix D (cont.)

Anderson, Cynthia
Wed 3/25/2020 11:13 AM

Landreth, Garry <garry.landreth@unt.edu>

Dr. Landreth,
Thank you very much for your response. That was extremely helpful.
I hope you and your family are doing well during these uncertain times.
I do have a couple of more questions if you have the time.
I am looking for this article but cannot seem to find it. Do you have access to this:

Kao, S., & Chang, J. M. (2007). A report on revising the Chinese version of play therapist attitude-knowledge-skills survey. *Psychological Testing, 54*(1), 121-146.
Also, my professor would like for me to include the name of the graduate assistant who helped you set up the Center for Play Therapy at UNT.
I have not been able to find a name. Could you help me with that?
Again, thank you. I value your input.
Cynthia Anderson
Take care!
I will contact Dr. Lindo as per your advice.

Correspondence with APT for the membership roster

Esther Gomezegomez@a4pt.org
Wed 7/29/2020 9:59 PM

Hello Cynthia,

Thank you so much for your patience. I am super excited to inform you that your list is complete, and I have attached it to this email. There are a total of 5,873 emails of APT members with US addresses. I am unsure if you wanted Guam included, but I left those records listed for you.

Feel free to let me know if you have any questions.

Thank you!
Esther

Esther Gomez
Senior Coordinator, Member Relations
Association for Play Therapy, Inc.
401 Clovis Ave. #107 | Clovis, CA 93612
(559) 298-3400 x 306 | Fax (559) 298-3410 | a4pt.org
Mental Health Professionals Applying the Therapeutic Power of Play!

Appendix D (cont.)

Facebook Counselor Group Administrator Approval

https://www.facebook.com/ 07-23-2020 to 08-15-2020

Your request to post in Therapists in Private Practice (TIPP) has been approved.

Your request to post in Professional Mental Health Counselors, Social Workers, & Psychologists has been approved.

Your request to post in Licensed Professional Counselors has been approved by the group administrator.

Your request to post in The Elementary School Counselor has been approved.
Your request to post in License Professional Clinical Counselor Support Group has been approved.

Your request to post in School Counselors Connect has been approved by a group administrator.

Your request to post in Mental Health Professionals Group has been approved by a group administrator.

Your request to post in School Counseling Essentials has been approved.

Your request to post in Play Therapy Community has been approved.

Correspondence Regarding Number of Professionals Credentialled in Play Therapy

Cynthia Anderson
Tues 9/1/2020 5:18 PM

Hi Esther,
My research project went very well. Thank you for your help.
I got good response from the various licensures and RPT credentialled counselors.
I was wondering how many RPTs, RPT-Ss, and SB-RPTs there are total for each category.
Could you send me those numbers? I'm writing that into my implications.
Thanks again,
Cynthia Anderson, RPT
St. Mary's University doctoral student

Esther Gomez
Thu 9/3/2020 2:29 PM

Appendix D (cont.)

Hi Cynthia,

Thank you for the clarification and I am so sorry for the delay in responding. I had to receive some assistance in pulling these numbers as I typically only pull membership numbers. The credentialing numbers as of today are as follows:

SB-RPT - 28
RPT-S - 2,037
RPT - 2,642

Please let me know if there is anything else I can further assist you with.

Thank you,
Esther

Esther Gomez
Senior Coordinator, Member Relations
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(559) 298-3400 x 306 | Fax (559) 298-3410 | a4pt.org